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MENTAL HOSPITAL MANUAL

JOHN MACARTHUR

OXFORD MEDICAL PUBLICATIONS

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BY

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PREFACE

THIS book is designed as a practical handbook, which I hope will do something towards satisfying a want expressed to me by not one, but many medical men. It is an endeavour to place before the newly joined medical officer in a mental hospital, as concisely as possible, those methods of treating the insane which experience has proved to be satisfactory. Nothing in the way of treatment has been recommended which has not stood the test of experience, and the opinions of practical men only have been sought.

A medical man who takes up work in a mental hospital will at first have to face many situations in which no matter how well qualified he may be professionally, he is ignorant of the correct practice, and it is to assist in such cases that the book has been written. No attempt has been made to give even the briefest account of mental diseases, for information on which subject the reader is referred to the many excellent and up-to-date works by both English and Continental authors. Similarly, the debatable subject of Psycho-Analysis has been barely outlined, in view of the wide choice of literature on the subject which is now available.

I hope that any errors which may have crept in will be at once pointed out.

I have naturally made free use of the books of many writers, the value of whose work has been already recognised.

In conclusion, I have to express the hope that the efforts of the more progressive public bodies in England to increase facilities for the early treatment of mental disease by the establishment of Out-Patient Departments, Clinics, etc., in addition to the improved teaching now available at the Maudsley Hospital and several of the Universities, will have far-reaching results.

A diminution in the number of cases ultimately requiring certification owing to the former lack of facilities for early diagnosis and treatment, may thus confidently be expected in view of the increased knowledge of the subject which will be at once available to the medical profession.

JOHN MACARTHUR.

March 1921.

CONTENTS

CHAPTER I

THE MENTAL HOSPITAL

THE MENTAL HOSPITAL:—Purposes for which it exists (Mercier)—special design.

I. WARDS: 1. Acute Admission—2. Infirmaries—3. Observation Wards for Epileptics, Suicidal Patients, etc.—4 and 5. Chronic and Working—6. Convalescent.

II. ADMINISTRATIVE BUILDINGS:—Keys. . . . pp. 1–7

CHAPTER II

THE ASSISTANT MEDICAL OFFICER

THE ASSISTANT MEDICAL OFFICER:—His Duties with regard to (1) Patients, (2) Staff.

I. PATIENTS: His General Responsibilities—His Rounds—Rules of Commissioners of Board of Control—Complaints of Patients—Clinical Notes—General Advice.

II. STAFF: Examination of New Staff—Education of Staff—Medical Treatment of Staff . . . . . pp. 8–24

CHAPTER III

TREATMENT OF THE INSANE

General Treatment—Open-air Treatment—Dietetic—Medicinal: Sulphonal, Paraldehyde, Chloral Hydrate, Bromides, Veronal, Trional, Amylene Hydrate, Opium, Chloralamide, Phenacetin, and Antipyrin, Hyoscine and Hyoscyamine, Croton Oil, Thyroid, etc. . pp. 25–40

CHAPTER IV

TREATMENT OF THE INSANE (contd.)

Psycho-analysis—Hydrotherapy—Employment of Patients—Seclusion—Mechanical Restraint—Artificial Feeding—Weighing—Searching of Patients—Menstruation—Pessaries—Artificial Teeth—Pregnancy and Confinements—Lumbar Puncture—Patients' Entertainments and Amusements . . . . . pp. 41–67

CHAPTER V

EMERGENCIES

Surgical Operations on Patients—Use of Anæsthetics—Common Emergencies, Hernia, Tracheotomy, etc.—Struggles—Casualties—Choking—Retention of Urine—Duties of Assistant Medical Officer in case of Fire pp. 68–77

CHAPTER VI

TREATMENT OF SPECIAL MENTAL STATES

States of Excitement—Sleeplessness—States of Depression—Suicidal Tendencies—Homicidal Impulses . . . . . pp. 78–97

CHAPTER VII

TREATMENT OF SPECIAL MENTAL STATES (contd.)

Epileptic Patients—Imbeciles—General Paralytics . . pp. 98–112

CHAPTER VIII

PATIENTS OF DEFECTIVE HABITS

Spitting—Faulty Habits—Masturbation—Persistent Removal of Clothing—Destructiveness—Self-mutilation—Rubbish Hoarding—Filth Eating pp. 113–121

CHAPTER IX

ADMISSION OF NEW CASES

Notes—Eighth Day Statement—Case Taking—Correspondence—Letters from Relatives—Visitors—Illness Notices . . . . pp. 122–142

CHAPTER X

RECOVERIES

Discharge of Patients: (1) Pauper—(2) Criminal—(3) Private pp. 143–150

CHAPTER XI

CONTAGIOUS DISEASES, ETC.

Contagious Diseases: Tuberculosis—Dysentery—Enteric Fever—Scabies—Parotitis.

Other Diseases Frequently Affecting the Insane: Insane Ear—Herpes Zoster—Circulatory Disorders—Chilblains—Gangrene pp. 151–167

CHAPTER XII

RECEPTION OF PATIENTS

LEGAL CONTROL OF THE INSANE: Lord Chancellor—Masters in Lunacy—Board of Control—Public Asylums—Licensed Hospitals—Licensed Houses—Single Patients—The Lunacy Acts of 1890 and 1891—The Mental Deficiency Act of 1913—Other Acts.

PAUPER PATIENTS: Summary Reception Order—Transfer of Pauper Patients.

PRIVATE PATIENTS: Judicial Order on Petition—Urgency Order—Transfer of Private Patients.

SERVICE PATIENTS.

CRIMINAL LUNATICS . . . . . pp. 168–198

CHAPTER XIII

STATUTORY BOOKS, NOTICES, ETC.

STATUTORY BOOKS: Medical—Recertification, etc.—Escapes.

SPECIAL DUTIES: at Inquests—Swearing of Affidavits.

DEATH OF PATIENT: Post-mortem Examination—Notices of Death pp. 199–212

INDEX . . . . . pp. 213–215

THE MENTAL HOSPITAL MANUAL

CHAPTER I

THE MENTAL HOSPITAL

THE MENTAL HOSPITAL:—Purposes for which it exists (Mercier)—Its special design.

I. WARDS: 1. Acute Admission—2. Infirmaries—3. Observation Wards for Epileptics, Suicidal Patients, etc.—4 and 5. Chronic and Working—6. Convalescent.

II. ADMINISTRATIVE BUILDINGS:—Keys.

THE purposes for which a mental hospital exists cannot be better summarised than has been done by the late Dr. Charles Mercier in his book on *Asylum Management and Organisation*, which, although published in 1894, still remains a standard work. He says that a mental hospital exists "for the detention under care and treatment of persons who are inclined to be either melancholy or turbulent, have tendencies to injure themselves or others, and are unable to protect themselves from ordinary sources of danger."

The principles upon which it should be constructed are such as "to make it a healthy residence, to provide for the complete and continuous supervision of its inmates, and to facilitate treatment."

He lays stress on the separation of the patients into "small groups," and even if this desirable end cannot

always be attained, it will be seen later that success in treatment, as well as economy of administration, depend on the careful classification of patients according to their mental condition.

Classification presupposes an accurate knowledge of the patient, and no medical officer should remain in the service unless he is prepared to acquire this. If the point appears in any way to be laboured in the chapters to follow, it is the author's firm belief that knowledge of the patient is the medical officer's sheet-anchor, and without such knowledge he is of little use to the place.

The construction of mental hospitals varies greatly throughout the country, and many of them were erected long before any reasoned treatment of mental disorder was in vogue. Many were designed entirely with a view to economy, and accordingly to herd, rather than to treat patients; but latter day ideas have produced beneficial changes even in such places, and many of the older hospitals have been greatly improved in structure, and in the standard of comfort the patients obtain.

The special design of a mental hospital is much as follows :—

The hospital is in two halves, devoted to the care of male and female patients respectively, with, in addition, certain administrative portions which are usually situated between the two main divisions in order that both sides may be served with equal facility.

The wards on each side are, as a rule, similar in construction, and consist of day-rooms, dormitories, and single rooms, with a sanitary annexe and lavatory accommodation attached to the day-room, or, as in the newer buildings, placed so as to be accessible to both day-room and dormitory.

The position of the single rooms varies in the

different classes of ward, and, as a rule, the ward opens either directly, or by means of a staircase, into an airing-court or garden, so that the patients have access thereto without passing through other parts of the building. In any case, there is a double exit in the event of fire.

There should be a main bath-house for each side of the institution to which the patients from the individual wards proceed for bathing purposes, with the exception of those in infirmary wards, who are, as a rule, bathed in the ward.

Some hospitals have also detached villa accommodation which may be used for a variety of purposes, e.g. the reception of acute cases, the segregation of cases suffering from tubercle, dysentery, or other contagious disease, and the treatment of convalescent patients. In addition there are frequently villas for the housing of farm and garden workers only.

I. Wards.

The most important wards in any hospital, however constructed, are :—

1. The Admission Wards.
2. The Infirmaries.
3. The Observation Wards for Epileptics, Suicidal Patients, etc.
4 and 5. Chronic and Working Wards.
6. Convalescent Wards.

1. **The Admission Wards.**—In the modern hospital new admissions are all received in the one ward, the Admission Hospital, which is preferably an entirely separate villa or block. Here all patients are kept in bed for at least a week, with a view to continuous supervision and observation, as well as to ensure a period of complete rest. In many cases this period of bed treatment is carried out in the open air by means of verandas.

The ward contains a special medical examination

room fitted with all the necessities for examination, and the room is in such a position that the medical officer can converse with the patient without being overheard by other patients.

There is also in the ward an ordinary bath, with a fitting attached to the supply pipes which enables a constant stream of water at a fixed temperature to be supplied, and a movable wooden covering to the lower two-thirds, by which means a patient may be given a continuous hot bath at a temperature of 100° F. lasting for anything up to four hours, a form of treatment which has proved of the greatest value, especially in restless maniacal cases.

In this admission hospital recoverable cases stay from the time of admission until the acute stage is over, when they are removed to a convalescent ward or block, in which a larger amount of liberty than is possible to the ordinary patient is permitted, and from this ward many of them go out daily to some form of employment.

Constant supervision, night and day, exercised by an adequate staff, is necessary in this ward probably more than in any other, as most of the patients are new, very little is known about them, and the risk of accident is naturally greater. Sufficient padded and single-room accommodation should be provided, not only for the treatment of acute states of excitement, but also in order that any case in which a suspicion of contagious disease exists, may be strictly isolated for the moment.

2. **The Infirmaries.**—The arrangement with regard to infirmary wards varies in different hospitals: in some, each medical officer has his own infirmary, to which he transfers any of his patients who may be sick, and in which he treats them; in others, one medical officer has charge of several infirmary wards, which draw their patients from other sections.

The former arrangement is undoubtedly the best, as it prevents the medical officer from losing sight of his own cases and thus losing interest in them. The same remark applies to the head nurse of the particular section, who accompanies the medical officer on his rounds.

The most desirable form of infirmary is simply that of the open dormitory with the day-room continuous with it, or at any rate opening into it. Single and padded rooms must be provided, and the lavatory and sanitary accommodation should take the form of a spur which has doors leading both into the dormitory and day-room, as already mentioned.

Specialised infirmary wards for the care and treatment of tubercular cases or those suffering from dysentery, enteric, etc., are becoming more and more widely recognised as a necessity, and are best when they take the form of villas. Whilst the management of these wards is carried out on ordinary medical lines, special difficulties are always likely to arise owing to the fact that as all classes of the insane are liable to contract such disorders, it is not always possible to carry out the accurate and rigid classification of patients which is regarded nowadays as being essential to their general welfare.

One infirmary should be fitted with a room or theatre for surgical operations, in which everything required for emergency operative treatment is at hand, and there should also be a room for dental work.

3. **The Observation Wards.**—These are wards designed for the treatment of special cases, such as epileptics, or suicidal cases, etc. Experience has shown that epileptic patients prefer to be with others who are similarly affected, and this is clearly shown in the solicitude that one epileptic will display towards another suffering from a seizure.

Night observation is, of course, essential in these wards, and occasionally it may be necessary to employ a special night nurse in addition to the ordinary one, in the case of an epileptic suffering from either *status epilepticus* or *furor*.

In the chapter devoted to the treatment of special states, a full account of the method of handling epileptics is given, and it will be then more easily appreciated how necessary separate wards are for such patients. The same degree of observation is the ideal also for suicidal cases, but the numbers of these are of course much smaller, and less ward space is consequently required.

4 and 5. **Chronic and Working Wards.**—Such chronic patients as are usefully employed are as a rule segregated in special wards which require less observation than the ordinary ward, and which may be closed during working hours if desired.

With regard to workers in special branches, such as farm and laundry, it is usual to collect them also in separate wards, as they consist mainly of chronic harmless cases. As has been already noted, the farm workers frequently inhabit a villa set apart from the main building and run largely on open-door lines, this plan having proved very satisfactory both as regards the health and comfort of the patients and the output of work.

6. **Convalescent Wards.**—If possible, these should be away from the main building, and again a separate small villa with its own garden is the best. The patients enjoy the freedom, and are placed in the most advantageous position as regards the attainment of full recovery.

II. Administrative Buildings.

The administrative portion of the building usually includes, in addition to the private quarters for resident medical officers, the various offices, stores,

kitchens, and workshops, and also probably the dispensary, chapel, recreation hall, and laundry, but in some of the more recently constructed hospitals the chapel has been designed as a separate building entirely.

The arrangements as regards keys in a mental hospital are of some importance. Usually two suites are provided, one for the male and one for the female side. The key supplied to the male staff will not open locks on the female side and vice versa.

The medical officer is supplied with a key, which, whilst admitting him to all the ordinary wards, will also remove the double locks which are fitted to certain doors. It will not take the farm and stores locks, however, but the M.O. in charge of the male side is usually given ordinary pass keys of these suites in order that he may visit such of his patients as are employed in these departments of the hospital.

When the M.O. leaves the hospital, it is usual for him to deposit his keys at the lodge for safe keeping.

CHAPTER II

THE ASSISTANT MEDICAL OFFICER

THE ASSISTANT MEDICAL OFFICER:—His Duties with regard to (1) Patients, (2) Staff.

I. PATIENTS: His General Responsibilities—His Rounds—Rules of Commissioners of Board of Control—Complaints of Patients—Clinical notes—General Advice.

II. STAFF: Examination of New Staff—Education of Staff—Medical Treatment of Staff.

PERHAPS the most convenient way to commence a description of the duties of the assistant medical officer is to consider them from the separate points of view of patients and staff.

1. HIS DUTIES WITH REGARD TO PATIENTS

He is usually placed in charge of a particular section of wards, which includes an infirmary and one or more observation wards. A particular head nurse is, as a rule, allotted to the section and accompanies him on his rounds. He makes a full round of all his wards twice a day at least, and, in addition, may be called for emergencies at any time. He is responsible for the treatment of all sick patients in his own section, and for transferring patients from one ward to another in his own section, as may frequently be necessary. On certain days of the week, according to the arrangement he makes with his colleagues, he is also responsible for the admission and examination of new cases, and in the larger hospitals he is available on these days for emergency work in wards other

than his own. On such days his whereabouts must therefore be at all times known to such persons as head nurses, hospital telephone operators, and gate porters.

There must be no delay in the admission of new cases ; too many of them are already on arrival at the hospital in a precarious state as the result of continued excitement or agitation, and any delay other than that necessary to see that the Reception Order is in proper form, is of the greatest detriment to the patient.

On days on which he is not admitting new cases, his time can be very fully and usefully employed in his own wards. On his morning round he thoroughly examines and treats all the sick (patients or staff), he examines the mental and physical states of such patients as require noting-up on the case sheet, writing the notes then and there, and he makes such general disposition of patients throughout his section as may be necessary to secure quietude and comfort for the majority. The morning round is usually completed by an inspection of the food served for the patients' dinner in one at least of his wards daily.

In the afternoon he may have a post-mortem to perform, new cases to write up, or such work as the laboratory examination of specimens of blood, urine, sputum, etc., which would take too long a time on his morning round. He may have to deliver a lecture to the staff, or attend one or other of the patients' entertainments. He will be expected to visit his wards again before bed-time, and to undertake a complete night round in turn with his colleagues.

The foregoing may be regarded as a general description of the routine duties of the A.M.O., but as this book is primarily intended for the use of medical officers, and especially for those who have recently joined, a much more detailed account is

necessary, and is dealt with under various heads in the following pages.

Rounds of Wards.—No man can possibly work in a mental hospital for more than twenty-four hours without noticing the absolute necessity for carrying a note-book. The substitution of case sheets kept in the wards for case books kept in an office, has certainly lessened the need for memorising small points which are much more conveniently noted on the spot, but many questions arise, and incidents occur, which the medical officer will consider it necessary to report to the medical superintendent, or to note for his own private information, whilst he may possibly consider them unsuitable for inclusion in the statutory records.

Usually the medical officer's morning starts with a visit to the medical superintendent's office, where he will be called upon to report on anything unusual which may have occurred amongst his patients on the previous day or during the night. It is usual at this time for the correspondence relating to patients to be given to the medical officers concerned; this consists chiefly of inquiries with regard to the progress of patients from relatives or friends; correspondence from the Board of Control, Boards of Guardians, etc., is usually dealt with by the medical superintendent personally. Before answering any letters it is wise for the A.M.O. to see the patient, so that no chance of any inaccuracy can occur as might happen, e.g., in persons of the same name, unless he is familiar with all his cases—and no newly joined man will be.

After this the officer usually meets the head nurse or head attendant, who accompanies him on his round, and to whom all orders respecting patients should be given. In most hospitals the notes regarding patients are made nowadays on sheets kept

RULES OF THE COMMISSIONERS IN LUNACY *

(June 26, 1895).

12. Within seven days after the admission of a patient there shall be entered in the medical case book for patients the following particulars.

(*a*) A statement of the name, age, sex, and previous occupation of the patient, and whether married, single, or widowed, and a copy of the statement of facts contained in the medical certificate accompanying the reception order.

(*b*) An accurate description of the external appearance of the patient upon admission:—of the habit of body, and temperament; appearance of eyes, expression of countenance, and any peculiarity in form of head; physical state of the vascular and respiratory organs, and of the abdominal viscera, and their respective functions; state of the pulse, tongue, skin, etc.; and the presence or absence on admission of bruises or other injuries.

(*c*) A description of the phenomena of the mental disorder:—the manner and period of the attack, with a minute account of the symptoms, and the changes produced in the patient's temper or disposition: specifying whether the malady displays itself by any, and what, delusions, or irrational conduct, or morbid or dangerous habits or propensities; whether it has occasioned any failure of memory or understanding; or is connected with epilepsy, or ordinary paralysis, or general paralysis.

(*d*) Every particular which can be obtained respecting the previous history of the patient, what are believed to have been the predisposing and exciting causes of the attack; what were the previous habits, whether active or sedentary, temperate or otherwise; whether the patient has experienced any former attacks, and if so at what periods; whether any relatives have been subject to insanity or other nervous disease, or phthisis; whether the present attack was preceded by any, and what premonitory symptoms; and whether the patient has undergone any, and what, previous treatment, or has been subjected to restraint of personal liberty.

13. Subsequent entries describing the course and progress of the case, and recording the Medical and other Treatment, with the results, shall be made in the case book for patients at the times hereinafter mentioned, that is to say: once at least in every week during the first month after reception, and oftener when necessary; afterwards, in recent or curable cases, once at least in every month, and in chronic cases, subject to little variation, *once in every three months*. But all special circumstances affecting the patient, including seclusion and mechanical restraint, and all accidents and injuries, must be at once recorded. A printed copy of this and the last preceding rule shall be inserted at the beginning of every case book for patients.

* Now Board of Control.

in the ward, either in the form of one of the loose-leaf systems, or else as plain sheets, the entries on which are copied into statutory case books, in which case the Board of Control consider it essential that the entries must be initialed by the medical officer.

Notes on patients must be made as follows:— On admission, after forty-eight hours, on the eighth day (this note is usually supplied by the medical superintendent's report to the Board of Control), weekly for one month, monthly for three months, and afterwards three-monthly for the rest of the patient's stay. A register is kept in a diary which shows which patients are due for notes each day. It is customary for the head nurse to have these patients kept in to see the medical officer, either in their own ward or in the section infirmary, in order that he may have the opportunity of examining them before writing the note due. In many cases, particularly of deluded patients who have been under certificate for a long time, and are therefore aware that their ideas are regarded as abnormal, considerable difficulty may be experienced in eliciting spoken evidence of insanity, but the head nurse or charge nurse can usually supply information of great value.

The diet for patients is, as a rule, ordered on a diet sheet kept in each ward, which shows, not only all special and substituted diets, but also the number of patients on the ordinary diet laid down for the institution. This diet sheet must be signed or initialed by the medical officer daily. Special diets required for patients who have been taken ill since the last round was paid to the ward, must be ordered in a special book supplied with a counterfoil, as the diet summary made from the ward sheets has to be sent to the stores twenty-four hours previous to the date of issue. It must be laid down that no sick diet should be ordered without its

being clearly shown that such diet is *substituted* for the ordinary diet, unless a definite order is given for extra diet, as otherwise the patient's ordinary food might be supplied in addition to the sick diet, and there would be unnecessary waste.

In the event of any patient making complaints about treatment by the staff, the following procedure is wise, viz., to hear the complaint and the evidence of any witnesses, inform the particular nurse or attendant concerned of the complaint, and as to whether it has been confirmed or denied by others, hear what he or she has to say, and report the whole matter in writing to the medical superintendent, who alone is able to deal with such cases. A note should always be made on the clinical record of such complaints, and as to the patient's condition, physical and mental, found on examination, as bruises or injuries may be present and may confirm the statement made, or the mental state may be such as to render the statements unreliable.

Notes.—In making a statutory note upon any individual patient, the idea in the mind of the medical officer should always be that he is writing a medical certificate, and that he may at some future date be called upon to justify his note. It should consist of facts only, and if some of these have been provided by the nurse, and not observed by himself, this should be stated. The facts should be such as indicate insanity, e.g. disorders of conduct and behaviour, definite false beliefs, failure of judgment, reasoning, or memory. A note that the patient is "clean, tidy, and industrious" is not evidence of insanity. All statutory notes should terminate with a statement as to the patient's physical health, his weight at the time, and the ward in which he resides.

A note should be made of any illness, casualty, transfer from one ward to another, adjudication to

WARD.....

Daily Number of Patients.

Sunday .....
Monday .....
Tuesday .....
Wednesday .....
Thursday .....
Friday .....
Saturday .....

MENTAL DIET AND

NAMES OF PATIENTS	DAILY AUTHORITY OF MEDICAL OFFICER.							ORDINARY BREAKFAST.			ORDINARY DINNER.		ORDINARY TEA.			COMPLETE SUBSTITUTIONS.		PARTIALLY SUBSTITUTED DINNER.	BREAKFAST.										LUNCH.				
	Sunday.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.	No.	Cocoa.	Coffee.	No.	Tea.	No.	Cocoa.	No.	Coffee.	No.	Tea.	No.	Mince Meat.	No.	Other Dinner Substitution.	pts.	Coffee	pts.	Cocoa.	pts.	Tea.	pts.	Milk.	pts.	Liquid Custard.	pts.	Porridge.	No.	Eggs.	oz.	Bacon.	oz.	Bread.	oz.	Butter.	pts.	Porridge.	pts.	Liquid Custard.	pts.	Arrowroot.	pts.	Milk.	No.	Bread and Meat.

HOSPITAL.

For the Week Commencing Sunday.....192 .

SICK LIST.

DINNER.			TEA.		SUPPER.	GENERAL EXTRAS.	
No.	Boiled	Fish.	pts.	Coffee.	pts.	Arrowroot.	No. Tobacco.
No.	Fried	oz. Minced Dinners.	pts.	Cocoa.	pts.	Porridge.	oz. Snuff.
No.	Mutton Chop.	oz. Beef Steak.	pts.	Milk.	pts.	Beef Tea.	oz. Extra Bread.
pts.	Beef Tea.	pts. Mutton Broth.	pts.	Liquid Custard.			oz. Butter.
oz.	Mashed Potatoes.	oz. Green Vegetables.	No.	Eggs.			oz. Tea (Dry).
No.	Baked Custard.	No. Tapioca Pudding.	oz.	Bread.			oz. Sugar.
No.	Rice do.	No. Sago do.	oz.	Cake.			No. Lemons.
pts.	Arrowroot.	No. Jelly, ½ pt.					No. Oranges.
pts.	Milk.	pts. Liquid Custard.					oz. Lime Juice.
oz.	Bread.	No. Meat Dinner.					pts. Rice Water.
No.	Poultry do.						pts. Barley Water.
							Syph. Soda Water.
							Bot. Stout.
							oz. Brandy.

another parish, complaint by patient or friends, appearance before sub-committee, tube feeding, bed treatment for mental illness, transfer from pauper to private or "service" class or vice versa, and a note on every occasion that the patient is examined physically or mentally.

One day weekly, always the same day, the medical officer should make a point of seeing all those patients who are on suicidal parchments, and deciding whether or not it is necessary for special observation still to be continued. At the same time the dysenteric, enteric, and tubercular tickets (if any) should be laid out for inspection. Any patient who has been reported as "restless" during the night should be seen and examined physically, as it is only by constant examination that an asylum officer can protect himself from being unaware of certain injuries to which the insane are liable, e.g. fractured ribs. Patients who are faulty in their habits and confined to bed, should be regularly examined to make sure that no soreness or scalding has arisen.

Any casualty reported must be examined before the casualty slip is initialed and the entry made on the case sheet. The medicine cards of such patients as require the repetition of a previous mixture are laid out for his inspection, and it is for him to decide whether medicine is to be stopped or continued; in either case he must indicate his orders on the medicine card.

It may be difficult for a man who is entirely fresh to mental hospital work to grasp exactly where his duties to patients begin and end. Briefly, it may be said that anything affecting, or which is liable to affect, the patient's health, comes within his province. This statement, however, needs qualifying to some extent, as certain matters in this connection are under the direct control of other officers, e.g.

the question of clothing. The officers responsible for this are the matron and inspector on their respective sides of the house, and anything which the medical officer may consider inadvisable or harmful should in the first place be pointed out to the responsible officer, who can then deal with the matter if due to default in some subordinate. On the other hand, the moment a patient becomes ill, the entire responsibility devolves on the medical officer, and any measure which he may think necessary should be ordered by him, and steps taken to see that his orders are properly carried out. Similarly with regard to food; the supply of the ordinary dietary as laid down by the medical superintendent is the business of the steward or storekeeper, and any cause of complaint should in the first instance be reported to him. But when a patient is ill, the responsibility for seeing that the special diet necessary is supplied by the stores is that of the medical officer, who is expected to see that suitable diet is substituted for the ordinary, and not merely added as an extra thereto.

General Advice.—There is one rule in the first place which it can be safely said is all important in the life of an asylum medical officer, viz. loyalty to the medical superintendent. He is primarily responsible for the administration and welfare of the institution, and is entitled to the fullest support and confidence of his medical colleagues. No deviation from the normal routine, even of the most trivial variety, should ever be sanctioned, much less initiated, without his full knowledge and consent, nor should any information affecting the building or any inmates thereof ever be concealed from him. At the same time, no medical superintendent desires to be incessantly worried by trifles and petty complaints, and he is entitled to expect his officers to use their own judgment and common sense

in the matters they report, and those they deal with personally.

Secondly, with regard to the relations with subordinate staff. The custom which has been found in many big hospitals to work well is as follows :— that each medical officer on his official round of the wards is accompanied by the head male or female nurse, these officials standing in the same relation to him as a non-commissioned officer in the army does to his superior. Through them all necessary orders are given, and it is their duty to see that they are carried out ; orders should not in the ordinary routine be given to the charge attendant or nurse. In the same way any member of the staff who desires to consult the medical officer professionally, should first approach the head nurse, whose duty it is to see that the individual in question is afforded an opportunity of seeing the medical officer.

Thirdly, with regard to patients, one safe and general rule may be laid down ; that the more intimate and individual knowledge the officer has of the patients under his charge, the more successful he is likely to be in his treatment, and the more valuable to the institution. All information about patients is valuable, and no detail of history, habits, or physique is too small to be noted. With reference to this point, it may be stated that in many cases far more information as to a patient's mental state is often obtained by a conversation at a dance or on some social occasion than at the time of interviewing him when one of his statutory notes falls due. The insane patient is a very human person, and is, as a rule, extremely quick to realise when a man is interested in his work, and very rarely fails to remember that this individual is the doctor, and, after all, doing the best for his patients. There will always be a certain

proportion who will regard him as an unjust jailer, but even this class of patient can, as a rule, appreciate ordinary justice and kindness. To sum up, patients in a mental hospital have possibly more individuality as cases than those in general hospitals, and appreciate very much the individual attention which they have a right to expect. One difficulty with reference to this point may be mentioned here; some men find it hard to remember so many names and faces, but this is largely a matter of time and interest. Ease of memorising will eventually come to any man who is conscientious in his work, but there is no doubt that in many cases it is greatly aided by the systematic use of a private note-book. Once a good general knowledge of the patients in one's wards is acquired, it is usually easy to keep oneself abreast of new arrivals as they come in, more especially as it is the custom to keep them in one ward under constant supervision for a considerable time. One fact which should always be kept in mind in connection with the insane, is that they have a clear appreciation of the truth, and no promise should ever be made, or undertaking given, which the speaker is not prepared to carry out. This is particularly so with regard to the constantly recurring appeals for discharge; the answer that it is not possible to recommend the patient's discharge as you do not consider him well enough, is productive of far less harm and trouble than such statements as "I will see about it," etc.

There can be little doubt that, other things being equal, the staff as a whole prefer to work with a man who, out of work hours, throws himself wholeheartedly into the life of the place, who attends the staff dances, whist drives, etc., and possibly is a member of the hospital football or cricket side; and it is not necessary to remind men who play games that,

on these occasions, they are members of a team and must be prepared to play as such, and not in virtue of the official position they hold. No hospital can be a happy one in which the various officers do not cultivate friendly relationships one with another, and the only rule to adopt in this connection is the very old one, "Do as you would be done by." It may occur that one is called upon to live in more or less intimacy with another whom under normal conditions one would not have chosen for a friend, but such are the conditions of life, and it is necessary to give and take.

This may be a convenient period to refer to one golden rule in asylum work. If you are sent for, go at once. Asylum emergencies, when they occur, do so suddenly and are frequently grave in nature. If when you arrive on the scene you consider that you have been sent for unnecessarily, remember that at any rate that particular member of the staff thought that what he or she was doing was in the patient's interest, and that it is better to go twenty times in answer to unnecessary calls than to stroll round at one's leisure in time to be too late.

It is usual for officers to work in pairs with regard to absence from the asylum, e.g. when one is out, the other must be in, and prepared to do all work that may be necessary in the absentee's wards ; as a rule each pair of men make their own arrangements with regard to such absences, but two other persons should be aware that such and such a medical officer is out, viz. the medical superintendent, who is responsible for the administration of the hospital, and the head nurse or attendant, whose duty it is to summon a doctor if necessary. Unless he or she knows that one particular medical man is out, it is possible for valuable time to be lost in the case of emergency calls.

His Duties with regard to Staff

In addition to the ordinary treatment of illness among resident members of the staff who are entitled to medical attendance, the A.M.O. is required to examine candidates for appointment to the subordinate staff, as well as to help to prepare members of the staff for the examinations which they are now expected to pass.

Examination of New Staff.—This duty is, as a rule, carried out by the senior medical officer of the respective sides of the house. Before a new member of the staff signs an engagement form, a medical examination is necessary to ensure the fact that the individual is physically fitted for the work. The examination should be conducted with the candidate in bed, and should cover the following ground. Particulars of height, weight, chest measurement and expansion should be recorded; the condition of heart, lungs, etc., should be ascertained and the urine examined; the vision and hearing must be tested, as some hospitals accept staff whose refractive error is compensated by glasses and others do not. The presence of such conditions as flat feet, varicose veins, and hernia must also be noted. In female staff the examination for hernia is sometimes entrusted to a head nurse, but if this is done, a note stating by whom the examination was made should be added to the form. Moderate degrees of varicose veins or flat foot do not of necessity prevent a person from carrying out the duties satisfactorily, but the liability of both disabilities to become progressively worse must be remembered. Morbus cordis should be regarded as an absolute bar to employment in a mental hospital. In cases showing good general health and physique, but a large number of carious

teeth, employment should be made conditional on dental attention being obtained within a fixed period, as dyspepsia, pyorrhœa, etc., are potential sequelæ which may initiate a considerable spell of ill health. It may be pointed out here that any suggestion of hysteria, undue simpleness of mind, history of frequent headache, and anæmia are all points which may render a person undesirable for this form of employment, which needs a good standard of physical and mental health more almost than any other type of nursing.

Education of Staff.—The comfort and welfare of the insane depend, to an extent far greater than is as a rule recognised, on the treatment received from the subordinate as distinct from the medical staff, but as the nursing staff of asylums as a rule start with absolutely no experience whatsoever of nursing, physical or mental, they are entirely dependent on the medical and senior nursing staff for such tuition as will enable them to become in time efficient. Courses of lectures are given annually to such members of the staff as desire to obtain the First Aid and Nursing Certificates of the St. John Ambulance Association, and also the Certificates of Proficiency in Mental Nursing granted by the Medico-Psychological Association. These lectures are given by the medical staff of the asylum, and run concurrently with clinical demonstrations of practical work given in the wards by the matron, assistant matron, or head nurses. But in addition to these courses, an immense amount can be done if each medical officer on his ordinary visits to the wards will take the trouble to devote even a brief period to teaching in any case where it appears necessary. Such examples as the need for asepsis in all surgical procedure are at once obvious, as unless the absolute necessity for this and the reasons therefore are indicated,

it is quite impossible to expect an untrained nurse to live up to the standard desired. Similar points arise even more frequently with regard to mental nursing, and it should be the constant endeavour of the medical officer to do all that he possibly can to enable the staff to increase their own value and efficiency. Those members who desire to learn will welcome any help that is forthcoming, and people who do not so desire are unfit to remain members of the staff of any hospital. The committees of some hospitals have of late recognised this by announcing that they do not propose to promote to more lucrative positions any members of the staff who have not attended lectures and given evidence generally of a desire to improve in their knowledge of the work. A word of advice may not be out of place to any reader who may have to lecture to an asylum staff for the first time. The lecture must be brief, certainly not more than an hour; the language must be simple, free from medical terms and long words, unless these are definitely and clearly explained, and the more dogmatic within reasonable limits the better; it is no use discussing abstract theory; concrete facts are more valuable to the nurses and much more useful. Finally, it must not be taken for granted that the class is in possession of any knowledge whatsoever of medical detail; unless that fact is realised, it is possible to talk at length to an absolutely mystified audience.

Medical Treatment of Staff. — Members of the resident staff in a mental hospital are, as a rule, entitled to medical attendance, and in the larger hospitals it is unfortunately not uncommon to have several of the junior staff off duty at one time.

Some hospitals possess a regular staff infirmary, whilst in others it is necessary for the nurse to be treated in his or her own room. When a medical

officer finds it necessary to send any member of the staff off duty, he should notify the matron or inspector, as the case may be, in addition to the medical superintendent, as these officers are responsible for the proper staffing of the wards.

Cases of infectious disease, or those requiring surgical interference, should be at once reported to the medical superintendent, who will decide as to the disposal of the case.

In all cases of grave illness, a letter should be sent to the relatives, informing them as fully as possible as to the condition, and the hours at which the sick nurse can most conveniently be visited.

CHAPTER III

TREATMENT OF THE INSANE

General treatment—Open-air Treatment—Dietetic—Medicinal: Sulphonal, Paraldehyde, Chloral Hydrate, Bromides, Veronal, Trional, Amylene Hydrate, Opium, Chloralamide, Phenacetin and Antipyrin, Hyoscine and Hyoscyamine, Croton Oil, Thyroid, etc.

General Treatment.—As time goes on, the treatment of the acutely ill mental case approximates more and more closely to the hospital treatment of acute bodily disease, and in no way is this more clearly shown than in the case of new admissions. These are all admitted to the Acute Hospital, where they are put to bed in an open dormitory, and, if possible, on a veranda. It is remarkable how frequently an excited, restless, and noisy patient becomes quiet and amenable when treated on these lines in the open air, possibly in conjunction with continuous hot baths, given in the evening before the day staff go off duty.

There are, of course, exceptions who must, not only for their own safety, but from the point of view of the other patients, be treated in a single or possibly a padded room. In the depressed and miserable case also a marked change is frequently to be noticed after a few days in bed in the open air; appetite, sleep, and interest are noticeably improved, and the distressing agitation and apprehensiveness diminished. In any case where the physical state is poor, with anæmia of a more or less marked degree, treatment in bed in the open for a period of weeks, and sometimes even longer, produces results which are superior to

those of any other form of treatment. In suitable cases, and provided that night staff is available, this treatment may with advantage be carried out during night as well as day.

Possibly, the class of case giving most trouble under these conditions is the acutely hallucinated one, where the patient may spring out of bed and rush into the ward-garden, believing that he can see or hear his enemies, children, etc. This type of case should not be kept in the open if giving active trouble of this sort: he probably will do quite well in a single room, with the door left widely open, and his behaviour is liable to give rise to excitement, distress, or alarm amongst the other patients.

Attention must be given to the warmth of the patients: open-air treatment is obviously only likely to be productive of harm if the temperature of the case is not maintained. Extra blankets, hot water bottles, and bed jackets or gowns, must be available, and restless patients who persistently would otherwise have their arms and chest uncovered by bed clothes must be provided with flannel vests in addition.

Care must also be taken to see that due attention is given to the patient's comfort with regard to the ordinary requirements of nature: if the accommodation provided is in the form of a commode, screened off on the veranda, the staff must be made to understand that the patient must be well wrapped up with blankets whilst at stool.

Another point to observe is to see that such patients as are on ordinary diet receive their food really hot. Food cools rapidly in the open, and hot food is more essential to these acute cases than almost to any other class of patient.

The same principle of open-air treatment applies, with modifications, to more chronic cases, as too

much stress cannot be laid upon the necessity for improving and maintaining their bodily health. At the present time, a very considerable proportion of the patients of any mental hospital spend more time in the open air than they did previous to admission—the ideal is for the patient to be in the open air night and day, and, even when this cannot be attained, the open window should be the rule in all wards, no matter of what type. At the same time, warmth is essential, and it is worse than useless to allow an acutely excited case confined to a side room to wander about in a state of nudity if the window be open. The same criticism holds good for those infirmary wards which are particularly reserved for elderly patients, but it may be taken as a general rule that the more fresh air a patient can be induced to breathe, the better for him.

Nowadays the ward-garden is not the only place of exercise; country walks, organised open-air games, etc., all form part of the general hospital routine, and the patients in many wards during the summer months take all their meals in the open, with marked benefit to their general health, and there is also no doubt that if chronic cases are kept out of doors as much as possible, there is a marked diminution of noise and excitement.

Dietetic.—It has long been recognised that it is just as necessary to lay down a definite dietary in the case of an acutely ill mental case, as in one suffering from grave physical disorder. The plan formerly widely recommended of feeding the patient with as much food as he or she could be induced to take, has gone out of favour, but there is no doubt that certain cases derive marked benefit as the result of a period of overfeeding. On the other hand, when a patient is placed on large quantities of extra food, care must be taken to ascertain, as far as possible,

whether the individual is capable of dealing with it, as many cases, especially of acute mental illness, are unable to assimilate more than quite small amounts of easily digestible food. Many superintendents and committees are now endeavouring to institute a late meal for, at any rate, a proportion of their patients, the custom which used to hold in many county mental hospitals of giving nothing between tea at 5.30 p.m. and breakfast at 8 the next morning being regarded as opposed to the well-being of most patients, and such an interval is undoubtedly too long. The A.M.O. in a modern hospital is able to order practically anything that he may consider necessary for the patient, no restrictions being placed upon his orders for patients' sick and extra diet, and the routine dietary is considerably more liberal and varied than was formerly the case.

Experience has shown also that many chronically insane patients, with a long history of recurrent excitement, noisiness at night, destructiveness, etc., derive marked mental benefit from dietetic treatment, either by change of feeding, alteration of meal-times, or additional nourishment, and such measures should always be tried before resorting to medical treatment. Whilst it is necessary, at any rate in county hospitals, to study economy so far as is consistent with the patients' welfare, there can be little doubt that, other things being equal, it is more desirable to spend money on food than on drugs.

Ordinary Diets.—Apart from the responsibility of ordering substituted diets for such cases as need them, the medical officer is responsible in his own wards for seeing that the ordinary diets are correctly and properly served to his patients. He should memorise, if possible, the asylum scale of diet, so that if a complaint be made to him about the amount of food, he is able to say what the actual allowance is.

But in case of doubt, there is in each ward a scale of diet for the information and guidance of the subordinate staff which he can consult. It is the duty of the charge nurse to see that, firstly, she receives the proper amount of each article of food from the kitchen, and, secondly, that each patient receives his or her proper proportion. In the event of complaint as to amount, if any doubt exists—for example, in the case of meat—the portion should be weighed, but it is necessary to remember that the amount shown by the patient as the issue for dinner may not be the amount which was on the plate when it reached him. If the A.M.O. is satisfied that the amount reaching the ward is less than the amount to which that ward is entitled by scale, a message to that effect should be sent at once to the stores or kitchen, and if any dispute or difficulty arises in obtaining the full amount to which the patients are entitled, reference should be made immediately to the medical superintendent. Should any article of diet be in the opinion of the medical officer unfit for consumption, either by reason of its bad quality or faulty preparation, the superintendent should again be informed at once. A further point which should be noted is the temperature, not only of the hot food when it reaches the ward, but also of the utensils on which it is served. It is unfair to the kitchen to serve a slice of hot beef with gravy and vegetables on a cold plate, and then complain that the patients' food is not hot. It is worth while taking very considerable pains to see that the plates for dinner are really hot ; in a ward with open fires it is perfectly easy to ensure this, and even when fires are not available, results almost as satisfactory may be obtained by the use of hot water, altogether apart from the use of special plate-warmers. Another point which is of importance is to see that not only the

crockery, but the knives and forks are scrupulously clean. This is a point which may very definitely affect the health of the patients, and as such it comes directly within the province of the medical officer, and any faults observed in this direction should be noted for reference to the matron or inspector, as it means failure of the subordinate staff to carry our their ordinary duties. A medical officer should, if possible, see dinner served in one of his wards each day. Tea and breakfast are less important, but with regard to these meals reference may be made to parcels sent by relatives. The contents of these are frequently presented to the medical officer for his approval or otherwise, and here he will be guided by the rules of the particular hospital, but in all cases of doubt, the welfare and safety of the individual patient is the best guide. The authorities of some hospitals forbid all meats and fish unless potted in glass containers; others take a broader line. Fruit, unless perfectly sound, should be condemned without hesitation, as it is a constant cause of intestinal disturbance. Needless to say, jams, sweets, and cakes are, as a rule, sanctioned in most hospitals.

Medicinal.—In the case of a person of unsound mind, any form of bodily illness may occur, and will, of course, be treated on ordinary medical lines, but there are some drugs in common use in mental hospitals which are not often used in the general practice of medicine, and it is necessary to indicate a few of those most usually employed.

Sulphonal (dose, 5–30 grs.) is not so much used as formerly, but is still a valuable drug, especially in maniacal states, as it is a motor depressant. It is, unfortunately, practically insoluble and so bulky that large doses cannot conveniently be given in cachet; probably it is best administered as a powder,

washed down with a little warm milk or stirred up in the same vehicle. Certain warnings as to its administration are necessary. It is slow in action, and for that reason may at times usefully be combined with Paraldehyde ; it is also cumulative in its effects, and particular attention should therefore be paid to the bowels of patients who are taking this drug regularly, whilst an effort should be made to increase the amount of fluid taken during the twenty-four hours. If given over a prolonged period, in certain cases Hæmatoporphyrinuria may be produced, a condition which is stated by many writers to be usually an indication of a fatal termination. It has also been urged against Sulphonal that it has a definitely destructive effect on the nerve cell, but this has not been proved. Many experienced men believe that Sulphonal is a fruitful cause of diarrhœa, and there is no doubt that it is an intestinal irritant. Any liability to this affection is lessened by using somewhat diminished doses of the drug, and adding small doses of Pot. Brom. and Mag. Sulph.

Some patients who have taken Sulphonal for a considerable period, unless protected from the sun, develop a form of skin lesion resembling a burn or scald on the face (usually on the forehead), and backs of the hands. The relationship of this disease to Sulphonal is not clear, but it is not often seen except in patients taking the drug.

The toxic signs are loss of muscular co-ordination, drawling speech, vomiting, slow pulse and subnormal temperature, in addition to marked drowsiness. Bed-treatment, warmth, and rectal injections of hot saline and coffee, with small doses of stimulant in hot milk by the mouth, will, as a rule, effect a complete recovery in twenty-four hours. A course of saline aperients should be given subsequently. To sum up : Sulphonal is a useful drug, but not without risk,

and it is possibly best given in combination with Pot. Brom. and Mag. Sulph. Any patient taking Sulphonal should be seen at least twice daily by the medical man, and a careful watch kept on the urine from day to day.

Paraldehyde.—One of the oldest and most extensively used of hypnotics, and also probably the safest—usually given in doses of ʒj to ʒij. Martindale and Westcott describe a case in which ʒiij were taken in error, no treatment given for nine hours, and yet the patient recovered after thirty-four hours' unconsciousness. It has a most unpleasant smell and taste, the former of which, unfortunately, persists in the breath of the patient; it may also upset the patient's digestion to some extent, and thus lead to refusal of food.

Its advantages are its safety, its rapid action, the fact that it is a cardiac stimulant, and its rapid excretion. One point that must be borne in mind is that, if given over a prolonged period, patients develop a marked liking for the drug, and will deliberately become noisy in the early part of the night in order to procure a dose, a definite habit being easily induced. Its offensive taste is probably best masked in an almond mixture, capsules containing any dose of value being too large for convenience.

It should also be noted that occasionally one meets a patient with an idiosyncrasy for the drug, a small dose producing vomiting and giddiness.

Chloral Hydrate (dose, gr. v–xxx), is very soluble, and not unpleasant to taste, acts quickly, leaves no unpleasant after effects, and is fairly quickly excreted. It must, however, be classified as one of the dangerous hypnotics, as it depresses both circulatory and respiratory systems. At the same time, in some maniacs it definitely increases the motor excitability. It should never be given to

patients except in bed, and not then to persons suffering from valvular or fatty disease of the heart or any form of renal disorder. It is valuable in the acute phases of epileptic insanity, such as furor, status, etc., when combined with Bromides. It is one of the active drugs in the preparation known as Bromidia, a variety of which is in use in many mental hospitals. It is wise in all prescriptions containing Chloral Hydrate to add a small dose of some cardiac stimulant.

Bromides—Potassium, Sodium, Ammonium, Strontium (dose, gr. v–xxx)—all are in common use, but all tend to hasten dementia if given over prolonged periods. They tend to the production of Bromide acne, although the Potassium salt seems to be most effective in this way. They should always be given in combination with small doses of Liq. Arsenicalis, and certain other drugs appear to act to advantage when combined with them, Hyoscyamus and Cannabis Indica more particularly. The Bromides in medicinal doses are not powerful enough to cope with the more acute mental conditions satisfactorily, and are most commonly used to intensify the action of some other sedative or hypnotic, except in the case of the epileptic, where most men still prefer them to anything else. They are readily soluble, not markedly unpleasant to taste, quickly excreted, and may at times be found very useful in maniacal states in which alcohol is regarded as being the causative factor.

Veronal (dose, gr. j–vij).—This is one of the many drugs which have from time to time been vaunted as the perfect hypnotic and sedative. In small doses it certainly prolongs sleep if the patient definitely " goes off " to sleep, but it frequently fails to produce sleep itself. In full doses, many observers have reported unpleasant effects, and for this

reason its use has been discontinued in some hospitals. It is not readily soluble in water, but is recommended to be given in hot tea, or as a powder followed by hot milk. It is almost tasteless, acts within an hour, and should never be given over any extended period.

Trional (gr. x–xxx), **Tetronal** (gr. x–xx), **Medinal** (gr. v–x), are all powders not unpleasant to take, insoluble in water, and, therefore, to be given as powder or cachet followed by a hot drink. They have no advantage over Sulphonal, and are much less certain and regular in their effect. They are slow in action, although somewhat quicker than Sulphonal, and are cumulative. It should be noted that Trional is also stated to produce Hæmatoporphyrinuria.

Amylene Hydrate (♏ xxx–lxxx).—This is a liquid with a most unpleasant taste, stated to resemble a mixture of Camphor and Paraldehyde, and is best disguised by liquorice or peppermint; its action is rapid—practically as rapid as that of Paraldehyde and more prolonged. It is stated to be a cardiac stimulant, and is frequently valuable in young excited cases whose general health is not good. It does not appear to establish a habit, and the unpleasant taste is not persistent. It is only slightly soluble in water.

Opium.—Whilst still the most valuable hypnotic that general medicine possesses, Opium is not often given in mental hospitals, except for one particular type of case—the restless and agitated melancholic. Many of these cases respond extremely well to this drug, and especially to Liq. Morph. Bimeconat. The customary precautions as to the state of the renal and respiratory systems must be observed, and particular care taken to ensure regular and free action of the bowels. It may be said that

in the treatment of the insane, unless for purposes of relieving actual pain, Morphia should never be administered hypodermically, except in combination with Hyoscine or Hyoscyamine; it is obviously inadvisable to endeavour to alleviate a case of melancholia by substituting the Morphia habit.

Chloralamide, Phenacetin, and Antipyrin are quite useless as hypnotics for the insane, but Aspirin is frequently of value in inducing sleep in cases where pain is present, such as neuralgia, migraine, etc. It is best given with some hot tea or coffee immediately before the usual bed-time. Adalin has been recommended as a safe and reliable hypnotic, but I have no experience of it, nor of Urethane. Dial appears in lunatics to lessen the psychomotor restlessness, but possesses few, if any, advantages over the older sedatives.

Hyoscine, Hyoscyamine, and their salts are extremely powerful drugs which are, as a rule, used only in cases of grave necessity, such as acute maniacal attacks or, less frequently, in patients who develop an acute attack of suicidal intention. A most useful combination has been found to be a hypodermic tabloid containing: Hyoscin. Hydrobrom. gr. $\frac{1}{100}$, Morph. Sulph. gr. $\frac{1}{4}$, Atropin. Sulph. gr. $\frac{1}{150}$. Two of these given hypodermically act very quickly, especially if immediately following the administration the patient is secluded for ten minutes or a quarter of an hour. Both of these drugs are credited with producing vivid and very terrifying hallucinations, but as a general rule the patient passes into a deep slumber, and awakes to demand food after having slept for five or six hours. On the other hand, some patients, whilst remaining quietly in bed, do not sleep at all, or only for a brief period. There are many patent preparations of Hyoscine on the market, but none

of them appear to be as certain and satisfactory in their effect as the above-mentioned tabloid.

Croton Oil.—This violent purgative has largely fallen into disuse in modern treatment, but certain cases derive marked benefit from its use at particular periods of their insanity. The acute raving maniac with a foul tongue and mouth, slight rise of temperature and obvious constipation, who is excited, restless, noisy, and destructive, and possibly refusing all food, frequently responds to a couple of minims in half an ounce of Castor Oil faster than to any other form of treatment. Similarly, the epileptic in a state of furor, who is quite uncontrollable and unreasonable, will often subside more rapidly to the normal if this drug be employed. It must be clearly understood that the presence of hernia, or even of large femoral or inguinal rings, is a distinct contraindication to its use, and naturally it will be employed only for robust healthy cases, as the peristaltic contractions cause actual pain to some persons. It may be dispensed as an emulsion, and its small bulk is a great point in its favour, or it may be administered as noted above, in plain Castor Oil. It need hardly be pointed out that this drug should be used purely as a medicine, and no idea of punitive treatment should ever be suggested with regard to its use.

On no account should any person but the medical officer have access to more of it than the one definite dose ordered for the particular patient.

Thyroid.—In some cases this drug has been much recommended as a curative agent, apart from the well-known instances of cretinism and myxœdema. Especially is this the case in some cases of melancholia, particularly when associated with a stuporose condition. The patient must be kept in bed on a full and nourishing diet, and gr. v of the gland given

three times a day for a week. Careful records of pulse and temperature are essential during the period of treatment, and in the event of irregularity of pulse the drug must be stopped, and a mixture of Ammonia, Digitalis, and Strychnine substituted. If, however, at the end of the week definite mental benefit appears to have been derived from the treatment, it should be stopped for four days, and then a further week's treatment commenced with somewhat larger doses. The patient frequently begins to look unwell and to lose weight, and it is wise to warn the friends that such a condition is likely to occur before instituting this form of treatment. It is possibly unnecessary to state that the medical officer must convince himself that the patient's heart is normal, and it is rarely wise to persist with more than two periods of seven days each; but certain cases derive marked benefit from the treatment. As soon as the thyroid is stopped, steps must be taken to repair the loss of weight, and the ordinary asylum routine as to the care of melancholics resumed.

General Directions

When medicine is ordered for any patient, the medical officer should always give clear orders, not only as to dosage and number of times of administration during the twenty-four hours, but also as to the *time* at which it is to be given. Especially is this important with regard to times of meals and sedative mixtures. It is foolish to give a sedative at such time as to have the patient well under the influence of the draught by the time the next meal is due. Ordinary mixtures will be ordered in accordance with the lines generally laid down in pharmacology, but sedatives taken as a whole act

better and more rapidly if given during the progress of digestion.

Very seldom should medicine be given mixed with or concealed in food; it should be given so that the patient recognises that it is an ordinary incident of treatment. The giving of powders on bread-and-butter, etc., is a most fertile source of trouble; not only are delusions of poisoning possibly originated in this way, but any patient may misconstrue this method of administration into an endeavour to give some drug which is illegal, or which the medical officer does not want anyone to know that he is giving. If a patient refuses to take medicine which has been ordered, the medical officer should personally see him, and if reasoning has no effect, the patient should be tube fed with it. This may sound drastic, but is better practice than any attempt to administer it by subterfuge, and this observation applies with great force to the giving of strong purgatives, such as Croton Oil, Calomel, Jalap, etc.

Croton Oil should not be given on sugar or in tea, coffee, etc., to any patient who is capable of appreciating the fact, and only to such cases as by their grave condition may call for this form of administration as a purely medical measure.

All medicines issued for patients should bear the most exact instructions, not only as to dosage, but also as to time and method of administration. This may entail a certain amount of extra labour in the dispensary, but the additional safety thus obtained renders it well worth while; the staff should be taught that, in the event of a doubt arising about any medicine from any cause whatsoever, e.g. either because the colour is different or the dosage has been altered, they must not issue a dose until they have consulted the medical

MEDICINE CARD

Name.....*Regd. No*.....*Admitted*.....*Aged* .....

Ward.....

N.B.

Treated for.....

DATE.	TREATMENT.	PAGE.	DATE.	TREATMENT.	PAGE.

COPY OF MEDICINE CARD (issued for each patient on admission)

officer. Further, they should also be taught that all medicines must be accurately measured and administered from a perfectly clean medicine glass ; and that all medicines for internal administration must be kept in a cupboard used for no other purpose, and which is locked immediately after they have been dispensed.

CHAPTER IV

TREATMENT OF THE INSANE (contd.)

Psycho-analysis—Hydrotherapy—Employment of Patients—Seclusion —Mechanical Restraint—Artificial Feeding—Weighing—Searching of Patients—Menstruation—Pessaries—Artificial Teeth—Pregnancy and Confinements—Lumbar Puncture—Patients' Entertainments and Amusements.

Psycho-analysis.—With regard to this question there is very little that has not already been said by many men; the members of the medical profession, or, at any rate, such of them as work constantly amongst the insane, are divided into two camps, those for and against Psycho-analysis as a method of treatment.

With regard to patients who are under certificate, it may fairly be stated that lasting benefit has not been attained in the opinion of many observers, and as has been indicated by Sir James Crichton Browne, in mental hospitals Psycho-analysis is not new as a method of treatment, except in name. He has pointed out that every conscientious medical officer for many years has endeavoured, by means of repeated questioning, appeals to the emotions, and observation of conduct, to ascertain the exciting cause of the particular mental illness. Also, that according to some of the strongest supporters of this variety of treatment, the amount of time necessary for the elucidation of one particular symptom is such that no institution medical officer could afford it, in fairness to the rest of his patients.

Another point which has undoubtedly influenced

a number of English medical men against the method, is the undue insistence on the importance of the sexual element in all insane states. Nobody can work among the insane for long without meeting with a number of cases in which some sexual factor is obvious, but few of us would care to express the opinion that this number included the great majority of the insane, as has been suggested by some of the Continental writers.

Further, as a matter of experience, the awakening of old sexual memories is frequently productive of far more harm than good.

An additional difficulty, which arises when attempting to apply these methods to the insane, is the fact that it is in many cases extremely difficult, if not impossible, to obtain and retain their attention ; and practically all are agreed that Psycho-analysis is not likely to produce favourable results unless the particular patient is anxious and able to assist the physician so far as he possibly can.

An attempt is made below to summarise, as briefly as possible, the more common methods of Psycho-analysis, and for further information the reader is referred to the works of Jung, Freud, Brill, and Ernest Jones.

The methods of Psycho-analysis as commonly employed are as follows :—Free Association, Time Association, Dream Analysis, and Hypnotic Analysis. These different methods are all of value in different types of case, but one point is common to all : that it is usually inadvisable to initiate any form of analysis without first obtaining as full a history of the illness as possible, both from the friends and also from the patient in the ordinary course of examination, so that when the time for analysis arrives, patient and physician are already on terms which will assist the examination.

Free Association.— The physician, who is in possession of the patient's history, and of as many facts as possible concerning his previous life, endeavours to produce in him a state of modified consciousness, that is to say, one in which no particular idea occupies his mind to the exclusion of others. A hypnotic state is not desired, nor in any way necessary; what is desirable, is that such a mental state should be present as will tend, so far as possible, to the freest association of ideas. The doctor now mentions persons, incidents, or words which he has noticed in his original medical examination, or dreams that the patient has described, and endeavours to obtain ideas associated with them by means of which the real significance of the morbid ideas may be ascertained.

Time Association.— For this method a stop-watch showing fifths of a second is necessary and a list of a hundred common words. The list as commonly used can be seen in practically every work on the subject, but if any word has been noticed during the previous examination which seems unusual, or to which the patient appears to attach undue significance, it may be substituted for some word in the middle of the list. The patient is asked as each test word is mentioned, to say aloud the first word which is evoked in his consciousness by association. The examiner writes down the reaction word with the reaction time on his list opposite to the test word. When the list has been completed, the whole process is repeated with the view of observing if the same word is reproduced by the test words. The value of this method lies in the clues given, not only by the nature of the reaction and reproduction words, but also by the average reaction and prolonged times. In the normal person the average reaction time is stated to be 2·4 seconds.

Any clue given by a markedly prolonged reaction time should be followed up as closely as possible, both by means of questions and other associations; and Jung describes many other "complex signs," of which the most important are:—inability to respond at all to the stimulus word within a given period, stammering, repeating the stimulus word, giggling, apprehension of the stimulus word in an unusual sense, constant repetition of one particular word, and faulty reproduction of the reaction word when the list is gone over for the second time. If any particular test word is productive of more than one of these complex indications, it may be regarded as a clue, at any rate to *one* of the hidden complexes, and a prolonged and thorough examination should be undertaken in order, if possible, to bring it to the surface. There is never any doubt left when the actual complex is discovered—the patient as a rule is absolutely certain of its correctness, and will indicate the fact by some display of emotion. This fact, as has been indicated by many writers, is the most obvious proof that the findings by Psychoanalysis are not artificial, or, at any rate, arbitrary. This method is probably the most fascinating of the many which have been from time to time recommended, but there are few insane patients to whom it is of obvious value. In the first place, one is dependent to a very great extent on the patient's power of fixing his attention, which at once rules out quite a large proportion of the insane; secondly, it is extremely difficult to obtain any good results from one who is very suspicious or hostile; and, finally, there are unfortunately very few men in mental hospitals who can afford the enormous amount of time which is frequently necessary before even one slender clue is obtained. For these

reasons many men use two or more different forms of analysis in the same case.

Dream Analysis.—Freud describes all dreams as being composed of two parts, a latent and a manifest content, and suggests that they are the outcome of a struggle between a repressed complex and the "psychic censor." He further states that every dream is the outcome of a wish, and that its actual appearance represents the realisation of that wish; further, that the actual underlying thought in the manifest content of the dream is subconsciously distorted by the patient, by means of a process which has been called "Condensation." This process consists in a mixing of scenes, events, and words into one whole, which may in itself be symbolised. For example, in a dream an individual may be indicated by a composite personality composed of several distinct persons. The analysis of dreams is a long and difficult process, and it is only occasionally that information of value is obtained in insane patients, but in a case which appears to be a suitable one, it should never be neglected as an adjuvant to other methods.

Hypnotic Analysis.—This particular method needs but a brief mention, as it has very largely been discarded for the preceding methods. It consisted in inducing a definite degree of hypnosis in the patient, and then subjecting him or her to an examination in the belief that selective reasoning and judgment being excluded, it would be easier to extract associations from the subconscious. Of the many objections to this form of analysis, the most important is the difficulty of inducing the hypnotic state in any insane person.

To sum up further this admittedly brief and inadequate description of the various methods of Psycho-analysis, it may be said that, generally

speaking, those who have to deal with the insane have not met with the striking successes described by various observers whose practice lies chiefly amongst the neuroses.

In the infrequent cases of insanity which appear to hold out some hope of success by the use of these methods, it has been the almost universal result that any effect in a curative direction has not been permanent. Still, further work on this line is undoubtedly necessary, and especially in those cases which, whilst obviously "of unsound mind," exhibit a considerable element of hysteria; in obsessions if uncomplicated by other indications of mental disorder; and in cases of so-called "Volitional Insanity." But whatever form of analysis be undertaken, the observer will find that it is quite useless unless he has (1) the patient's entire confidence and trust, and (2) as complete a history as possible, not only of his illness, but also of his past life and habits.

Hydrotherapy.—Of late years increasing use has been made of this form of treatment in mental practice, particularly in the form of the continuous warm bath, which has already been mentioned. The morning cold plunge or shower is frequently a most valuable form of treatment in adolescent cases, particularly of the stuporose type, but should never be ordered without a previous careful examination of the patient's physical state. It is probably unnecessary to add that such baths should never be regarded as in any sense punitive, but always as a form of treatment, and for this reason cold baths should, as a rule, be ordered for a period daily, and not on one occasion only. The duration, whether of the plunge or shower, should be very short, preferably less than a minute, and the staff must be taught that the result hoped for is largely due to

the amount of reaction obtained. Immediately on leaving the bath, the patient must be thoroughly and energetically dried with a rough towel, and, so far as possible, kept from draughts and chills. In this type of bath in the case of females, if possible, the head should not be wetted.

Considerable benefit may be observed from this bath in masturbators, some feeble-minded cases, and adolescents, but it is rarely a suitable form of treatment for Epileptics.

The hot bath, apart from cleansing purposes, is frequently very valuable in troublesome cases of insomnia, the limit of temperature permissible being 105° F. It should be given about half an hour before the usual bed-time, and the patient put to bed immediately after drying.

The continuous warm bath, the temperature of which should not exceed 100° F., is given in the following manner :—

An ordinary bath is fitted with a cover provided with an opening for the head, a rest, usually of wood and shaped, is provided for the neck, and an adjustable support, against which the patient can rest his feet in order to avoid slipping down the bath. The bath is filled to a depth sufficient to immerse the patient's trunk completely, and kept at that level by means of an overflow. A mechanical device can be procured, and is in use in many hospitals, by which the hot and cold supplies mix in a chamber before entering the bath, and the temperature can never exceed that fixed at the start. The case which derives most benefit from this form of treatment is the maniacal one.

If the patient is acutely restless, it may be necessary to dispense with the wooden cover to avoid bruising, but although a certain amount of restlessness, splashing, etc., may occur for the first half hour,

a tactful and patient nurse can usually induce the subject to remain in the bath. Up to six hours is the time recognised as the limit for this form of treatment, although this has been greatly exceeded on the Continent; but it is advisable to begin on the first day with about an hour, and if the result is definitely beneficial, to increase the period daily. The patient must at all times be under observation, but an exception must be made in these cases to the rule that a head nurse must be present at all bathing. He or she should see the patient placed in the bath, but if the excitement shows signs of abating, it is not essential that this officer remain until the finish of the bath, so long as the nurse in charge has experience of the treatment, and knows what to do in case of syncope, etc. If the patient is a female, she should be clothed in a chemise or nightdress; and the author has found that a waterproof sheet spread over the top of the lower two-thirds of the bath has a restraining influence which, whilst purely moral, is at least the equal of the wooden cover in effect, and he has discontinued the use of the latter for some time past.

After a prolonged bath of this type, the patient should be dried as quickly as possible and put straight to bed. This form of treatment may safely be continued daily for weeks without harm to the patient's health so long as the strength is maintained by plenty of nourishing food, and is a much more satisfactory method of dealing with acute excitement than drugs, seclusion, etc.

A few mental hospitals are fortunate enough to have a properly fitted Turkish bath, and in selected cases there can be no doubt that this is a most valuable adjunct to treatment. The young adolescent who, after improving to some extent, suddenly comes to a standstill mentally, but continues to gain flesh

whilst losing energy, is the typical case to derive benefit from this bath. Certain melancholics, especially of the dull and hopeless type, also respond to Turkish baths, whilst the value of these baths in the treatment of many bodily ailments need not be recapitulated.

The medical officer must here also lay down the number of baths to be given—more than one weekly is rarely advisable—and also the duration of the bath. If he is fortunate enough to have amongst the staff one who has a knowledge of massage, the value of the bath is greatly increased. A sufficient number of staff must, of course, attend the patient whilst in the bath, and the patient on return should proceed to bed for the rest of the day.

The wet pack is rarely seen nowadays, its place having been taken by more modern methods, but if used at all, its use must be reported to the Board of Control, who regard it as one of the forms of "mechanical restraint." Medical attention must be instantly available.

Reference must also be made to the electric bath. The patient is given a warm bath, through which a weak current is passed—one electrode being placed at the foot of the bath and the other at the head. The electrodes must not be in contact with the patient's skin, and the bath must be made of some non-conducting material, such as earthenware or porcelain, and not of metal. Good results have been reported in the treatment of melancholics and stuporose primary dements by this means. The bath should be given on alternate days for about ten minutes at a time, and the current must be a weak one.

Employment of Patients.—A large number of insane persons are perfectly capable of useful and productive work of some kind or other, and in addition are happier and more contented people when

so employed. The medical officer should make himself acquainted in all newly admitted cases with their civil occupation previous to the mental breakdown, in order that, so far as is possible, when the time comes that the patient may safely be employed, the work provided is of a congenial character: in this connection, however, it may be noted that many patients when recovering mentally, prefer to be occupied in some form of employment as dissimilar as possible from their outside work.

In a county mental hospital, on the male side of the house, the farm and grounds supply occupation for a large proportion of the inmates; but, in addition, there are opportunities for employment in all the shops—boot-making, tailoring, upholstering, with its accessory branches of mat-making, basket-making, etc. In fact, in practically every office and department of the hospital patients may usefully be employed, and even in allotment work for their own benefit.

On the female side, housework, the laundry, and the needle-room occupy the energies of a considerable number of women, whilst some superintendents have attained great success in the employment of females in envelope making, book binding, and other more highly skilled trades, besides employing a certain number in gardening. The medical officer's responsibility as regards the employment of patients is one of considerable importance. No patient on his section should be employed, nor should the employment of any patient be changed without his knowledge; he is the one person who is responsible to the medical superintendent that the patient is (1) physically fit for the particular form of employment, and (2) mentally fit; in the event of any accident occurring, such, for example, as fainting attacks leading to injury, or the escape of a patient from

the farm, it will be from him in the first place that justification for the patient's employment in that particular form of work will be required.

It must be remembered that employment in a mental hospital is purely voluntary on the patient's part, and no compulsion can be used or should even be suggested; a certain number of persons can always be found who insist that if they can work in the hospital they are equally capable of working at home, and also that they are unwilling to work unless paid for so doing.

It must be admitted that one sympathises very greatly with a man who is a first-class tradesman and turning out good work for the hospital, but whom one is unable to pay. At the State Criminal Asylum at Broadmoor, a system of payment for work done has been running for a number of years, with good results to the Institution and to the greater contentment of the patients.

In most cases, however, the medical officer will find that patients who are recovering will themselves express a desire for employment. This desire may be stimulated by granting certain very minor privileges to patients who are physically and mentally capable of work. There is no doubt also that many patients themselves realise that the employment is useful to them from the point of view of treatment, even before this is suggested to them by the doctor.

The restriction upon the employment of epileptics and general paralytics by reason of the peculiar nature of their malady, has been touched upon elsewhere, and the medical officer will be wise to ascertain accurately the views of his superintendent upon the patient's employment before sending him to work in some part of the building where patients have not previously been employed.

Some superintendents do not approve of patients' employment in offices at all ; others may not desire a patient to assist in the photographic studio on account of the risk of poisoning, etc.

In any case, the one really important reason for employment of patients in as large numbers as possible is not to save the ratepayers' money, however desirable as a secondary result that may be ; the primary object is to assist the patient's recovery, and employment should always be regarded by the staff, not as *work*, but as a method of treatment of mental disease which time and experience have proved to be one of the most valuable in one's possession.

Seclusion.—By this is meant the isolation of a patient between the hours of 7 a.m. and 7 p.m. by closing the door of any apartment which he may occupy and preventing egress. The word "closing" in this connection may be taken to mean "fastening," which need not necessarily be done by means of a lock and key. A patient kept in a single room by means of a chair tilted and the back fixed under the door handle, is secluded. Seclusion is not so commonly used as a form of treatment as it was, but is still necessary from time to time in states of acute excitement and noisiness.

The patient is, of course, inspected at regular intervals by the nurse, and as soon as the required results have been obtained the method is abandoned. Some cases, especially those whose language is very obscene, and, as mentioned previously, those who are noisy and constantly endeavouring to clutch hold of and aimlessly struggle with other persons, derive the greatest benefit from short periods of seclusion.

It should be very carefully noted that in states of great excitement or epileptic furor, on no account must seclusion take the place of active medicinal treatment. If such cases as these are not dealt

SECLUSION

Date.	Ward.	Patient's Name.	Period.	Reason.

NOTICE OF SECLUSION

Medical Officer.

with immediately by methods of medicinal restraint, much greater evils, such as self-mutilation or serious injury of some kind, may ensue, and many unfortunate examples are recorded in the official reports of the Board of Control.

Seclusion must be reported in writing to the medical superintendent, with the duration and the reasons for its employment. It is not in the province of any officer or employee in an asylum, except the medical staff, to order the seclusion of any patient, and should any breach of this rule be discovered, the offence would be a grave one.

Mechanical Restraint.—Sec. 40 Lunacy Act, 1890, provides that mechanical restraint shall not be used unless necessary for purposes of medical or surgical treatment, or to prevent the patient from injuring himself or others. The use of this form of treatment is practically extinct in modern hospitals, and the author, in the course of fourteen years' experience, has never found it to be necessary, or seen it in use, except in the case of certain patients during the process of their removal to the hospital.

It may be well to state here that the Board of Control do not consider the use of splints, etc., in the case of fractures or such injuries, as coming under the heading of restraint. In the event, however, of restraint at any time being necessary, the medical officer must make out a certificate, stating the variety of restraint used and the reasons for its use ; if used on more than one occasion, a record of its use from day to day must be kept and sent to the Commissioners at the end of each quarter. Restraint must in any case be used only with the full knowledge and express sanction of the medical superintendent.

Artificial Feeding.—It may be convenient at this point to make a few remarks on the subject of refusal of food ; many insane patients refuse food at times,

and it is most important to ascertain, if possible, the reason. It may be due to delusion, e.g. that the food is poisoned, to acute depression and desire to die, to bodily illness which has escaped notice, etc. In cases where the patient expresses belief that the food is poisoned, it is always well to search for physical conditions, such as pyorrhœa or severe dyspepsia, treatment of which will probably put an end to the refusal. In any case, before resorting to artificial feeding, certain measures should always be tried, viz. a brisk purgative, and the substitution of liquid for solid diet, also in certain cases the use of enemata; but if the refusal is persisted in, artificial feeding should not be delayed more than twelve hours, as the loss of strength and bodily resistance is frequently abnormally rapid. When it has been decided to feed by tube, the following has been found to be one of the most convenient methods: the patient is placed in bed in a semi-recumbent position, well supported by pillows. The head nurse, standing behind the bed, holds the gag with her right hand after it has been placed in position by the medical officer, and supports and steadies the patient's chin with her left hand. A draw-sheet is placed across the patient's chest and arms, which latter are secured by a nurse on each side, holding them through the sheet to avoid any chance of bruising. The tube, lubricated with glycerine, is passed by the medical officer, and steadied by two fingers of the head nurse's left hand, and then the feeding mixture is introduced. It may be necessary in some cases to wait for a minute or so after the introduction of the tube to allow the violent straining which some patients exhibit to subside. The author is in the habit of using a Jaques 60-in. tube size 24, and has found, particularly in resistive and violent patients, that the additional length is of great assist-

ance, and the comparatively large size of the tube seems to prevent to some extent the regurgitation which is at times so troublesome.

Feeding should be done twice daily; on each occasion two new laid eggs, well beaten up in a pint and a half of milk, with possibly a small quantity of freshly made beef tea added, are usually found sufficient, but the bodily weight is the soundest and best method of estimating the success or otherwise of one's treatment. Sugar and alcohol may be added, and the mixture may be peptonised if necessary.

If regurgitation occurs, the head of the patient must be held over the side of the bed, so that the fluid contents of the mouth run out; the gag and tube should be removed, the mouth cleaned out, and the tube reintroduced and left in position for some minutes; the food should then be given as slowly as possible. If feeding has to be continued daily, it is essential that the stomach be well washed out before the operation at least every other day with warm water containing Sodæ Bicarb., a teaspoonful to the pint. Sedative draughts or any medicine considered necessary may be given at the same time as the feeding mixture, since the patient is unable to appreciate the taste of the mixture. Some medical officers prefer nasal to œsophageal feeding, but in mental hospital practice there are certain points in favour of the latter method. In the first place, a number of one's patients have definite dulling or loss of the reflexes, and it is quite possible to have an accident from this cause. Other points are that the nasal mucous membrane is very tender and easily abraded, and, owing to the small size of tube which is usually employed, the feeding is a longer process. In actively resistive patients it is undoubtedly more difficult to feed satisfactorily by this method, but it has the advantage of not needing a gag. If

it is decided to feed by the nasal route, it is just as necessary that the patient be secured in the semi-recumbent position as described above. The tube, lubricated with glycerine, is then passed, not necessarily into the stomach, a few inches down the œsophagus being all that is essential, and the allotted food administered. The same precautions are required in whatever form of forcible feeding is used, viz. to wait until breathing is regular and normal before starting to feed, and by means of regular lavage to maintain the gastric mucous membrane in as clean a state as possible. In addition, special care must be paid to the toilet of the mouth—advantage may be taken of the fact that the gag is in position thoroughly to clean teeth and gums on each occasion of feeding. Many cases who refuse food cease to do so, when once the mouth is clean and the contents of the bowels properly evacuated.

Weighing.—It is the custom to weigh all patients in a mental hospital once a month and record the weight on a special chart, which is kept in the clinical record. This chart is one of the most valuable indices of the results of treatment that the medical officer possesses, and he should always go through the weights the day after they have been taken, in addition to examining the chart of each patient upon whom he makes a statutory note. Certain fallacies should be guarded against if possible. The patient should always be weighed in the same state as regards clothing, by the same nurse, on the same scales, and preferably on the same day of the month, and a head nurse or attendant should be present. Inaccurate weights are most misleading, but can as a rule be recognised by the fact that several patients in the same ward show marked differences from the preceding month. A loss of weight in two successive months should always be an indication for a thorough

physical examination of the patient, as also should a sudden and pronounced loss if only for the month. If nothing can be found to account for the loss, it may be considered advisable to substitute some other diet for the ordinary scale, or to order extra food for the next week or so; or the patient, if not in an infirmary, may be transferred to such a ward in order that additional observation may be obtained.

In the wards set apart for the accommodation of tubercular cases, it is wise to have the patients weighed weekly, and the same precautions as to accuracy are equally essential. In mental illness, assistance in prognosis is obtained particularly in

Name .....

Change of Ward .....

	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.	St.	lbs.
January																		
February																		
March																		
April																		
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June																		
July																		
August																		
September																		
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November																		
December																		

WEIGHT CHART

cases of primary dementia, melancholia, and cases following parturition, but it must be reiterated here that a rapid increase of weight in an adolescent, unaccompanied by marked mental improvement, is an unfavourable symptom.

Searching of Patients.—It will be obvious at once that certain articles which practically every man or woman living a normal life possesses, must be strictly contraband in a mental hospital; as examples, it is only necessary to mention pocket-knives, matches, and scissors. It is found in practice that no matter how careful the supervision may be, certain patients will from time to time manufacture knives for themselves from scrap iron or old stay busks; the danger lies not in the good farm worker possessing a knife, but in the fact that he may lend it to another patient who does not come into the same category. Rules are laid down and enforced as to the disposal of such metal as may be used for the above purpose, but the manufacture of this form of implement will still go on, and the only method which deals with the position is thorough and sudden searching of the patients in the wards. Unless this is done systematically and without warning, various abuses in addition to the possession of weapons will arise; some patients will be found to have considerable sums of money on them, others to have articles of food in advanced stages of decomposition, in addition to various kinds of rubbish. Whilst the actual searching is, as a rule, carried out by the head nurses, the medical officer will frequently be approached on his next visit with requests for the return of certain property, and here he must, whilst conforming to the rules of the institution in regard to money, clothing, etc., use his own discretion with regard to small articles, not in themselves dangerous or harmful, to which the patient may attach considerable importance. The amount of money

allowed is usually limited to sixpence, and any surplus is lodged in the keeping of the clerk of the hospital. Some visitors to patients are incredibly foolish in bringing in articles simply because the patients ask for them, and a search immediately following the visiting hours frequently results in the discovery of much contraband.

Menstruation.—It is customary in many hospitals to keep in the female wards a book in which the charge nurse is held responsible for entering the duration of the menstrual periods of her patients. In some hospitals this book is kept in all wards, in others only in the Acute Hospital or Admission Block, whilst some institutions show the incidence and duration in the daily ward report. The record is a particularly valuable one in a hospital, not only in the case of new admissions and acute cases, but also in the chronic wards. The reappearance of the menses following a prolonged suppression is frequently one of the earliest signs of recovery in young patients, and continued amenorrhœa one of the worst from the point of view of prognosis.

In the older and more chronic cases again, the sudden reappearance of a vaginal loss may be the first indication of carcinoma or other pathological condition. Finally, it may seem unnecessary to point out that the absence of the monthly illness in a newly admitted and healthy woman should always lead to careful observation in view of possible pregnancy. On account of the value of this record, it is desirable that it should be kept on some document which accompanies each patient from ward to ward in the case of transfer, e.g. case sheet or weight chart, as by this means a continuous record can be kept, and it is not necessary to consult the books in each ward that the patient has visited. The influence of menstruation on the mental illness varies considerably

in different patients. In some epileptics it corresponds accurately with an attack of excitement or a succession of fits, and in some manic-depressive cases it occurs in definite relation to a particular phase of the malady. In melancholia, especially acute cases, amenorrhœa is a usual symptom, and it is practically invariable in female general paralytics. It is, however, not as a rule necessary to direct special treatment to the cure of this symptom, and attention directed to improving the general physical health will often be all that is required. The relation between the mental state and the genital apparatus in the female sex is undoubtedly a close one, and it may be hoped that further research may lead to valuable results.

Pessaries.—Uterine displacements are by no means uncommon in the insane, and need special mention in regard to the precautions which must be observed when it is considered necessary for a patient to wear a pessary. A vaginal douche should be given every other day, and the instrument removed and cleaned before reintroduction every month, when a speculum should be passed and the fornices and cervix inspected. A note should be made on each occasion that this is done. Unless this routine is carried out, it is possible for the fact that a patient is wearing an instrument to be forgotten or overlooked, either on account of a transfer from one ward to another, or because of changes of staff in the ward.

Artificial Teeth.—No patient should be allowed to sleep with artificial teeth *in situ*. The denture should be removed, carefully cleansed, placed in a separate receptacle containing ordinary clean water, and locked away for the night. Each receptacle must be labelled with the patient's name, and every care taken to ensure that no possibility of mixing the dentures occurs.

Pregnancy and Confinements.—Insanity occurring

during pregnancy is by no means uncommon : some writers state that one per cent. of all first attacks in women is due to this cause. When seen, it is very frequently found that other factors have been at work in addition to the pregnant state, e.g. illegitimacy of the unborn child, and death or desertion of the father. Probably a state of depression is the most common form that insanity takes in these cases, but the manic-depressive type and various states of excitement are also seen. When a patient is admitted who is known to be pregnant, she must, of course, be kept in an observation ward, where there is a permanent night nurse. After she has been in for a week or ten days, a thorough examination, including vaginal investigation, should be made, as it is not wise ever to accept a patient as being pregnant on her own or her relatives' statements. If the diagnosis is confirmed by examination, it is advisable to notify the relatives of the fact, and the patient should be examined at regular intervals to ensure that the condition is progressing normally. These cases rarely give any particular trouble or anxiety, and from time to time one sees cases in which the mental illness appears to be extraordinarily brief and fleeting. If by any chance it is possible to recommend such patients for discharge before confinement, this should be done, as the sentimental objection to having a child born in a mental hospital is still very great. Some mental hospitals have obtained the sanction of the local authority to notify these births as occurring at " the Infirmary," or some such name, in order to avoid any stigma being attached to the infant in later life.

On the other hand, if the patient's mental state is such as to preclude any possibility of discharge before her delivery, for some days before the expected date she should be allowed to sleep in a single

room in an infirmary ward (unless, of course, there are objections to this from her mental condition). All the ordinary necessaries for confinement should be in readiness in the ward. The actual confinement is rarely difficult and often precipitate. The child must be bottle-fed, and kept apart from the mother for twenty-eight days, at the expiration of which period the relatives are given notice to remove ; if they from any cause are unable or unwilling to care for the infant, in the case of a pauper patient, the Guardians to whom the child is chargeable should be communicated with. Special attention must be paid to the mother's breasts to avoid any complication until involution is complete. The child cannot, as a rule, be kept in the open ward, but is usually accommodated in a cradle in the ward kitchen, to which only certain well-known and trusted persons are admitted. It is not usual to have the child vaccinated during its stay in the hospital, but baptism, as a rule, is carried out.

Lumbar Puncture.—This operation has become increasingly common of late years in view of its importance from a diagnostic point of view, especially in doubtful cases of general paralysis. In this disease the proportion of lymphocytes is very markedly increased, forming over 60 per cent. of the total cells seen in the fluid. This fact, coupled with a positive Wassermann and the presence of plasma cells, is now accepted as definite proof of the nature of the malady. The puncture is best performed with the patient seated on a low stool and bending forward as much as possible. If a line be drawn between the highest points of the two iliac crests, it will pass over the fourth lumbar spine. A point is taken $\frac{1}{4}$ in. below the spine and the same distance from the middle line, and the skin rendered aseptic. A hollow platinum needle which

has been sterilised is thrust inwards and forwards for a variable distance, but which is on an average $3\frac{1}{4}$ in. If the point of the needle engages bone, it must be withdrawn slightly, and the angle which it makes with the spine noted before the attempt to find the canal is resumed. If no fluid appears when the operator is convinced that he is in the canal, a sterile stilette should be passed through the needle. The fluid usually escapes in drops, and should be collected in a sterile test tube, and the escape of the fluid in a stream is evidence that the pressure is increased. 10 c.c. is regarded as the maximum that may safely be removed. When the needle is withdrawn, the aperture is sealed with collodion, and the patient kept in bed for the rest of the day. Epileptics stand this procedure badly, but it does not appear to inconvenience the general paralytic in the least, and an anæsthetic is rarely, if ever, necessary.

Patients' Entertainments and Amusements. — As has been indicated elsewhere, a medical officer is expected to interest himself in the social life of the hospital as well as in his medical duties. The commonest forms of associated entertainments are dances, concerts, and whist drives. At patients' dances, members of the staff are expected to dance with the patients and not with one another; these occasions frequently afford extremely valuable opportunities of gaining an insight into a patient's mental state which is not easily obtained at other times, e.g. erotic tendencies, undue excitability or shyness, etc., will frequently manifest themselves. At concerts, theatrical performances, etc., the sexes are, as a rule, kept apart, and the chief point to be observed with regard to them is to see that such epileptics as attend are seated near to an exit in order that their removal, if necessary, may be effected with the minimum of disturbance to the rest of the

audience. It is often wise to send a suicidal patient who is showing evidences of regaining control to an entertainment of this sort, as the stimulus is frequently of value, but a special nurse who is well acquainted with the patient should always be detailed for the purpose. In the wards themselves, such amusements as dancing, cards, billiards, bagatelle, and many other well-known indoor games are indulged in every evening, at any rate in the less acute wards, and should be encouraged in every way. At such times as Christmas, a great amount of interest can be aroused by instituting tournaments at various games on the following lines. Each ward, during the six weeks previous to Christmas week, settles, by means of a knock-out tournament, who is to represent the ward against the selected candidates from other wards. These representatives take part in the competition proper, which is most conveniently played off during the "sitting up parties," so that the finals in each event, whether billiards, draughts, or other games, may be witnessed by as many persons as possible. The games which are probably most popular and suitable for this form of tournament are billiards, bagatelle, chess, draughts, and cribbage, but many others can be dealt with in the same way if sufficient competitors are forthcoming. The hour of "bedding down" in many large asylums is eight o'clock, and many superintendents, recognising this as an unduly early hour for such patients as do not require treatment by complete rest, have instituted "sitting up parties" in selected wards. These patients, in the main quiet chronic workers and convalescent people, are allowed to sit up until 10 p.m., or such hour as is decided to be suitable. This is a privilege which is enormously appreciated by many, and it is at such times that the various competitions de-

scribed can be most conveniently played off. Prizes may be obtained either by a grant from the Entertainment Fund or Tea Fund, and the medical officer will be amply repaid for any time and trouble expended, by the evident pleasure and interest shown in the various events, and the thanks which will be liberally conveyed to him by his patients.

With regard to outdoor amusements, cricket and football teams are run at most mental hospitals, and afford a great deal of pleasure to a large proportion of the patients, especially if some of their fellows are playing. On off days it is frequently possible to organise a match for patients only—one member of the staff being allowed to play on each side; here again the competitive instinct may be aroused by arranging such matches as Farm *v.* Indoor workers, etc. The referee at football and the umpires at cricket, however, should, so far as possible, be members of the staff. Athletic sports are also very popular, and, in addition to ordinary events, such as flat racing, jumping, and throwing the cricket ball, should include a number of the more ludicrous, such as obstacle race, sack, wheelbarrow, and three-legged races. Suitable obstacles are five-barred gates, a pole fixed 18 in. from the ground, a tarpaulin firmly pegged down under which competitors have to crawl, barrels suspended from a pole, and a rope maze through which they have to pick their way. For the female patients, potato races, egg and spoon, threading the needle, etc., are variations from the usual events. Such other devices as bobbing for apples in tubs filled with water, or buns dipped in treacle suspended from a pole, are also harmless and amusing. In events of this sort, the judges and starters should be officers who are intimately acquainted with the patients' names, as much heartburning may arise from an error with

regard to such matters, and the patients are much more readily satisfied with an officer's decision.

Other outdoor entertainments, in the form of picnics, hay-making parties, etc., can frequently be arranged during fine weather, and it may be noted here that most hospitals have now regular shopping parties, when selected patients can purchase such small necessities as they themselves and the other patients in the ward desire.

Patients whose mental state is such that permission can be given without danger to themselves or others, are from time to time allowed out for the day in the charge of a nurse to visit their friends, or to go to a matinée, picture show, etc. It is within the power of a medical superintendent to give leave of absence up to four days to a patient, either with or without a nurse, and a free use of this power is made in selected cases and when the home conditions are satisfactory.

CHAPTER V

EMERGENCIES

Surgical Operations on Patients—Use of Anæsthetics—Common Emergencies, Hernia, Tracheotomy, etc.—Struggles—Casualties—Choking—Retention of Urine—Duties of Assistant Medical Officer in case of Fire.

Surgical Operations.—From time to time it is necessary to undertake operative procedure on patients in mental hospitals, many of which now have their own surgical theatres, with all necessary conveniences, such as sterilisers, operating-tables, and special lighting arrangements, but if such are not available, it is easy to adapt some convenient room for the purpose. If the call for surgical interference is not urgent, the usual course adopted is to write to the relatives, giving an account of the nature of the disease, with an opinion that such and such treatment is necessary, and enclosing a typewritten form of consent to the operation for them to sign ; or they may be asked to visit, and the position explained to them. Whether a relative can legally refuse to sanction an operation deemed necessary in the case of an insane pauper patient is a question which has apparently never been settled in the Courts. On the other hand, in cases of urgency, such as strangulated hernia, ruptured gastric ulcer, etc., valuable time should never be wasted in waiting for the relatives' consent. It is wise to wire to them, but proceed with the operation forthwith.

Fortunately, as a general rule, insane persons take anæsthetics well, and give practically no trouble; but, if time allows, the routine preparation of the patient as laid down in any surgical work should be

carefully and thoroughly carried out. As in normal cases, the anæsthetist must select such anæsthetic as he considers the best for the individual case, and here it may be suggested that whilst every man probably has his own preference as to what to give, bad effects from chloroform are rarely seen in the insane. One point may be made, which is that epileptics frequently take both nitrous oxide and ether badly, particularly the former.

It is advisable to have a special nurse on duty on a surgical case for about twelve hours after the operation ; she can not only deal with any vomiting or other post-anæsthetic complications that may arise, but is in a position immediately to notice and report any restlessness or desire to interfere with dressings, if such should occur.

The most common operations of urgency which arise in mental hospitals are strangulated hernia or internal strangulation by band, ruptured gastric ulcer, rupture of bladder, and such complication of ovarian cysts as twisted pedicle. For some reason or other which is unknown, appendicitis is rarely seen in the insane, either as an acute attack or on the post-mortem table. On the other hand, malignant disease is fairly common, and appears to affect the same regions in order of frequency as in the sane population ; and every effort must be made to deal with such cases in as radical a manner and as early as possible.

Tracheotomy and laryngotomy are called for from time to time, almost invariably as emergency measures in cases of choking, and then, as a rule, must be undertaken by the medical officer alone, and without an anæsthetic. It need hardly be stated that in such cases, speed in opening the air passages is the only essential, and that all preparation and cleansing of the skin must of necessity be dispensed with.

Whether the hospital is equipped with a theatre or not, all necessities for surgical emergencies must at all times be ready. The ordinary instruments can be sterilised and kept in a sterilised metal case, and the dressings already sterilised in a special drum, which must also contain surgeons' aprons and gloves. All requirements for anæsthesia also should be ready in a particular cupboard. If this is done, a strangulated hernia or such emergency occurring at night can be dealt with with the least possible disturbance of the ordinary institution routine, and, it may be added, the minimum of trouble to the medical officer concerned. The theatre should be under the charge of one special nurse.

A point which arises here is one of considerable importance : if any article is borrowed from the theatre for use in a ward, every care must be taken to see that it is returned immediately after use, as otherwise, when suddenly required, nobody knows where it is and much valuable time may be lost.

Struggles.—In all cases where a struggle involving a patient occurs, the patient should be examined completely, and a note as to the result of the examination made at the time. Particular attention should be paid to the ribs and abdominal organs. It is wise at the same time to ask the staff concerned whether they are complaining of any injury themselves and to note anything found, as such lesions as hernia, etc., arising later may be stated to have arisen in such a fracas.

A book for recording such struggles is kept in the hospital, and in addition, of course, a note is made on the case sheet. Should any injury result from the struggle, it is entered in the special book as well as being recorded on the day or night report and in the medical journal.

REPORT OF STRUGGLE

192

Ward.....

There was a struggle between the Patient.....

..... and .....

at.....o'clock.

To the Medical Officer. Head Attendant.

If any injury is found, the medical officer must make himself certain that no others exist, e.g. the obvious injury may be a dislocation, but in addition there may be fractures, ruptured viscera, etc.

This last caution is of the greatest importance to the inexperienced medical officer, and if he is at all doubtful as to the result of his examination, he should have no hesitation in obtaining another opinion at once, and the patient should be kept in bed.

Casualties.—When any injury, however trivial, is observed on a patient, it is the duty of the charge nurse to draw the attention of the medical officer to it on his next visit.

He must then satisfy himself that no serious accident has happened to the patient, and that no blame can be attached to any member of the staff

CASUALTY REPORT

.....192

WARD.....

Name of Patient.....

Form of Accident .....

Caused by.....

Time .....

Nurse present .....

.....

Charge Nurse.

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in connection with it, by as full inquiry as possible into the circumstances under which it occurred. Having so satisfied himself, he will then initial the casualty report which has been made out in readiness for his visit, and make a note of the incident in the case sheet. If, however, he considers that any undue roughness or unnecessary handling on the part of the staff has occurred, it is his duty to report the incident in writing to the medical superintendent at once, at the same time mentioning the fact that he intends to do so to the matron or inspector, as the case may be.

The casualty slip is copied not only into the medical journal, which the medical officer must initial weekly, but also into the daily journal, kept by the matron or inspector on their respective sides of the hospital.

Choking.—This accident, which is far from uncommon in the insane, occurs usually in the following classes of patients:—epileptics, general paralytics, and senile dements. The ideal treatment of choking is to prevent it from happening, and whilst this can never be guaranteed, it may be rendered far less common if the medical officer pays particular attention to the diets which he orders for such patients. Such patients as general paralytics practically always should be on mince and slop diet. This may sound unduly harsh to the patient, but it is the only safe rule, as it is impossible without daily examination to estimate accurately the degree to which the swallowing reflex is affected.

With regard to epileptics and seniles, the chief points to take into consideration are, in the former, number, variety, and time of incidence of fits; and in the latter, general feebleness, and condition of teeth. Each case must be considered individually, and the question should be definitely asked of oneself, "Is this patient fit to be on ordinary diet?" It is not assumed that a mince diet will eliminate the risk of choking, but it undoubtedly goes a long way to diminish it. The so-called cut-up diet, which is simply an ordinary dinner cut up by the nurse before being given to the patient, is often actually a source of danger, unless the staff are very carefully taught and supervised. When a case of choking occurs, it may safely be said that the only person who is likely to do any good is the person on the spot; the patient should be laid upon his back, the mouth forcibly opened, if necessary, with the handle of a spoon or fork, and the contents of the mouth and fauces completely cleared with a finger, no instrument ever devised being half so good. If this clearing process is done rapidly and thoroughly, and artificial respiration started promptly, the lives of a large

number of cases will be saved long before the medical officer or head attendant can reach the ward. If nothing can be found in the mouth to account for the symptoms, the finger should be introduced into the œsophagus ; the narrowest portion of this canal is at the top, immediately behind the cricoid cartilage. If nothing can be felt, it is probable that the obstruction has been inhaled, and the question of laryngotomy or tracheotomy at once arises. If this is to be of any value, it must be done immediately, no time being wasted in the preparation of the patient or instruments. A sharp pocket-knife is all that is necessary for the actual operation of opening the air passages ; the introduction of a tube, if required, can safely be done at a later moment.

Experience has proved that by far the best method of training staff to deal with cases of choking is to make no reference to probangs or any other form of instrument, but to instruct them to open the patient's mouth, clear it with the finger, and, having done so, to commence artificial respiration if necessary. With regard to the latter procedure, even if unsuccessful at first, it must be maintained until all hope of recovery is lost. If respiration be re-established, warmth and stimulation should be applied to the patient in bed, and he should be rigidly kept there until all danger of any pulmonary complication has passed.

Retention of Urine.—This form of surgical emergency occurs from time to time in the male wards of a mental hospital, and usually, as might be expected, in general paralytics or senile cases. In the former it is generally due to the organic disease of the brain, and not to any local cause in the urethra. Such cases may be dealt with by catheterisation, which may have to be regularly performed twice daily for the rest of the patient's life ; but, as a rule, this is not so.

Incontinence is the usual condition in these cases for a varying period previous to death. In any case, even if the passing of a catheter be necessary only on one solitary occasion, the strictest asepsis is called for; and it may not be amiss to mention here that a surgically clean catheter passed by an equally clean hand through a soiled meatus is absolutely useless from this point of view.

In senile cases, retention is commonly due to stricture or enlarged prostate, and the first method of treatment in such cases is to allow the patient to spend ten minutes in a hot bath. If this is unsuccessful, catheters may be tried for not more than a quarter of an hour, when, failing success, it is usually advisable to aspirate the bladder suprapubically, again with the strictest aseptic precautions. The patient is put back to bed, given a morphia suppository, and in the morning it is usually possible to get a catheter or bougie through the obstruction. This having been done, the stricture may be dilated until it is large enough to accommodate a soft rubber catheter, which is then tied *in situ*, and steps taken to deal with the condition. If the attempt to pass a catheter in the morning result in failure, the bladder may be aspirated again, but three times is probably the limit of safety in this procedure, and some other form of operative interference should then be considered. Retention is sometimes seen in the female wards, but less commonly. It occurs as a rule in general paralytics or cases in which there is a considerable element of hysteria. With regard to the former, similar measures to those indicated in the case of male general paralytics should be carried out, but this is a condition of affairs which may quite possibly be overlooked in the case of a newly admitted female patient unless the medical officer is wary. In every new admission in which the appear-

ance, speech, or history are suggestive of general paralysis, special attention should be given to the bladder during the examination and the charge nurse definitely warned. In hysterical cases, catheterisation may be needed once or twice, but should be done by the head nurse, and if the diagnosis is clear and no contraindications exist, a course of cold morning plunges, nervine tonics, and suggestion should be at once undertaken. The medical officer is frequently in somewhat of a difficulty over these cases; whilst not desiring to attract the patient's attention to her sexual organs, he does not wish to miss any cause for the retention, but the passage of a soft catheter by the head nurse can do no harm, and may clear the condition up once and for all; the passage of a silver or glass instrument should not be sanctioned.

Fire Duties.—It is to be hoped that no reader of this book will ever be so unfortunate as to witness a fire in a mental hospital, but it is necessary for every medical officer to be fully cognisant of what is expected of him in the case of such an emergency. His duty on an alarm being given is to proceed at once to the site of the outbreak. The first thing to ensure is the safety of the patients—nothing else matters one iota to him at such a time; once they have been removed to a place of safety, other things can be considered, but the medical man's first duty is to his patients. It is needless to advise that steps must be taken to obviate panic, as that is an accident that no man can prevent, but the presence of their own medical officer in the ward is the one thing which is likely to reassure the patients. If a ward be definitely alight, the inmates should be turned out anywhere that is nearest, most convenient, and safest, whether it be a corridor, ward, or airing-court, but before removing them from the place of safety used in the emergency, they must be counted.

Counting is of no value unless accurate, and a startled or flurried nurse is not likely to be strictly accurate in enumerating a number of scared patients, and probably in a bad light; but unless this is done as early as possible, it cannot be ensured that everyone is in safety. In every mental hospital there is a set of rules drawn up for the guidance of the staff in fire emergency, and the medical officer must be fully acquainted with them. Of course the officer must be aware of what form the fire alarm takes in the particular hospital in which he is employed—whether an alarm-bell rings in the wards or a siren is sounded, etc. A further point of value is a knowledge of the position of all hydrants and stand-pipes on the estate, as in the event of his being the first person on the spot, this knowledge may enable him to save time, which is the essence of all measures for dealing with fire.

CHAPTER VI

TREATMENT OF SPECIAL MENTAL STATES

States of Excitement—Sleeplessness—States of Depression—Suicidal Tendencies—Homicidal Impulses.

States of Excitement.—All grades of excitement are seen in insanity, from what may be regarded as mild exaltation to a condition of acute mania, and by no means every case needs active treatment. There is practically no form of mental disease during which excitement of varying intensity may not make its appearance, but the most common conditions in which it occurs are acute alcoholism, toxic insanities, manic-depressive insanity, epilepsy, general paralysis, and less commonly dementia præcox and the various delusional states. From the clinical point of view, the treatment may be most readily considered by dividing the cases into transient and prolonged. The sudden acute attack of excitement, possibly originating from some altogether inadequate stimulus, such as a request by a nurse to sit down, needs immediate treatment, as, if not controlled at once, patients who are liable to these outbursts are capable of a great deal of damage to others, as well as to furniture, glass, etc. The first essential is removal to bed in a single or, if necessary, padded room ; the staff should be instructed in dealing with such patients not to attempt to deal with them single-handed. This form of foolishness leads to more struggles and casualties than anything else. With plenty of assistance it is possible to manage

the strongest and most determined patient, and a large proportion will attempt no violence if they observe that the staff are in a majority. Once in bed, if the attack is diagnosed as likely to be brief, a dose of calomel may be all the treatment that is necessary, and the patient will frequently be found to be in his normal mental state in the morning. If, on the other hand, when put to bed, the violence and noise continue, the combination of a hypodermic of hyoscine, with a brief period of seclusion, say, twenty minutes or half an hour, will usually produce the desired effect. Emphasis must be laid on the importance of keeping patients who are under the influence of a powerful sedative, such as hyoscine, warm and well covered with bed-clothes, and constant supervision should be maintained until the effect of the drug has passed off. If the patient sleeps through one of the ordinary meal-hours, his food should be kept and given him when he awakes, unless the medical officer considers it necessary to order some special diet.

When, however, the condition of the patient is such as to render it probable that the attack is likely to be prolonged, other forms of treatment become necessary, but the initial purge should never be omitted. Rest, so far as it can be provided, should be insisted upon. Bed in a single room, or, if the patient refuses to stay in bed, in a padded room, is the only possible form of treatment. In cases that wander about the room all day, it is frequently necessary to order extra clothing, as the ordinary nightdress is insufficient.

If the patient is destructive to clothing, a suit of flannel vest and drawers, under a strong linen combination frock, which is securely fastened behind, must be tried, because, unless the patient is kept warm, he is particularly liable to pneumonia or some other intercurrent malady.

It is almost always essential to substitute the diet of such patients by liquids, and every precaution must be taken to see that sufficient nourishment is obtained in the twenty-four hours. The continuous warm bath should be the first method to be tried when the case refuses to stay in bed. Patience and coaxing will frequently induce the patient to stay in the bath, and even if he does splash about for the first half-hour, no great harm is done and the treatment is persisted in. If, when replaced in bed, the excitement is still acute, a full dose of whatever hypnotic appears to be the most suitable should be given and the room darkened for an hour. Sedatives should, however, be used only when other measures have failed, or as adjuvants to them. Their routine usage is not productive of good results, and sleep procured by their help is not so valuable in the treatment of the insane as that obtained by other methods. To sum up, warmth, good and plentiful feeding, and sufficient rest are the necessities in the treatment of excitement—the first two are usually fairly easy to procure, the last frequently very difficult. If the case will not take food readily, other forms than the ordinary should be supplied before actual hand feeding is commenced—some cases who refuse food will take milk readily. The bowels should be kept acting freely, and, so far as possible, careful attention paid to the state of the mouth. If the patient be faulty in habits, observation must be unremitting to ensure immediate changing and washing, as some cases will in a short time smear themselves and their room in an indescribable manner, and filth eating is an occasional symptom.

A very important point to be noted in this connection is that in cases of acute excitement exhibiting these particularly filthy habits, a glycerine enema

or suppository given twice daily is of the greatest value, and more especially if firm at bedtime.

The chief dangers in this state are choking (in the ravenous type), and pneumonia and exhaustion with consequent heart failure. Purposeful violence towards others is uncommon, but if, as sometimes happens, a patient develops an intense dislike for some individual, it is only common sense to take such steps as will prevent the two from coming in contact. Visiting should be forbidden during any excited phase; it does no good to the patient, but usually harm, and is naturally distressing to the relatives. It is wise, however, if a patient is suffering from an attack of excitement of some duration, either to write to or make a point of interviewing the relatives, in order that they may clearly understand the risks and effects, immediate or remote, of the condition. Otherwise, on visiting the patient at the end of the attack and finding him possibly thin, haggard, and worn, and perhaps suffering from bruises or abrasions caused by his intense restlessness, the friends are likely to complain that he has been starved or ill used, and that their visiting was stopped in an endeavour to conceal the iniquities, so often alleged without the slightest reason to be practised by the staffs of mental hospitals.

Sleeplessness.—Insomnia is an extremely common symptom among the insane, and the causes of this distressing complaint are many and various. In newly admitted cases it is frequently only due to the new and strange conditions under which the patient finds himself, and it is not advisable to give a sedative draught until other methods of inducing sleep have been tried. It must be remembered that it is usual in a mental hospital for the patients to retire to bed much earlier than is customary for an adult living his normal life in the world,

HOURLY SLEEP CHART

Showing Number of Minutes Slept during each Hour from 9 p.m. until 6 a.m.

Name.....

Admitted.....*Reg. No*.....

	9 to 10 p.m.	10 to 11 p.m.	11 p.m. to Midnight.	12 to 1 a.m.	1 to 2 a.m.	2 to 3 a.m.	3 to 4 a.m.	4 to 5 a.m.	5 to 6 a.m.	9 to 10 p.m.	10 to 11 p.m.	11 p.m. to Midnight.	12 to 1 a.m.	1 to 2 a.m.	2 to 3 a.m.	3 to 4 a.m.	4 to 5 a.m.	5 to 6 a.m.
MINUTES. 60	*Date*																	
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and this in itself is sufficient to cause wakefulness in the early days of treatment. It is a safe rule, however, in an acute case of mental illness, not to allow a patient to be sleepless for more than two consecutive nights. The possibility of some bodily cause must not be lost sight of in cases where the mental state is not such as is usually associated with insomnia. Among female cases anæmia is a commonly overlooked cause, and in male cases over-smoking. Senility in itself is a sufficient reason for broken and short periods of sleep, especially if the arteries have reached a condition of marked rigidity. Insomnia is, as might be expected, a feature in acutely depressed and excited patients. General paralytics, except when in an excited phase, as also epileptics and patients suffering from delusional states unaccompanied by hallucinations, as a rule, sleep well. The effect of hallucinations differs widely in different cases, and it cannot be said as a whole that it is more marked when any one particular sense is involved. If no physical cause can be discovered, the simpler forms of treatment must be tried before recourse is made to drugs. Moving the patient's bed to a darker part of the ward or to a corner, or sometimes a transfer from a dormitory to a single room, or vice versa, is frequently all that is required. Some simple food, or the administration of a hot drink just before bed-time, does good at times to patients who have been used to a late meal. In male patients, the prohibition of smoking after tea will sometimes work wonders. In debilitated cases, such as puerperal cases or anæmic primary dements, who are semi-stuporose, a small amount of stout is often the most effective hypnotic. Alcohol has of late become unfashionable as a means of treatment, but if the cases are carefully selected, it is still a most valuable drug, and used in medicinal doses does not

readily induce the alcoholic habit. Stout is probably the most suitable form in which to administer it. When it becomes necessary to use drugs, the choice is large. *Opium* is rarely desirable, unless the cause of the sleeplessness be pain, as the danger of a habit being induced is a very real one in the case of this drug. The *Bromides* are probably the safest, and if only one be used, the potassium salt is that most commonly employed. *Chloral* in small doses is also useful, but its dangerous action on the heart must be kept in mind. It is wise to put the patient who is receiving it on a cardiac stimulant as well. *Adalin* is a mild hypnotic, safe and non-cumulative. *Bromural* is a preparation of a similar nature, and may be employed in the same dosage, namely, gr. v – x. *Medinal* and *Dial* have been recommended by various writers. *Veronal* is not now regarded as so safe as it was formerly supposed to be. Whichever drug is used, it must be clearly borne in mind that the measure is only a temporary one, and must be discontinued as soon as possible.

The use of baths as a method of sleep induction has already been described. It is usual to issue to all newly admitted cases a sleep chart on which is recorded graphically by the night nurse the amount of sleep actually obtained by the patient, and if accurately and conscientiously kept, this is a most valuable method of estimating the result of treatment.

In certain cases of melancholia, massage of the neck, slowly and gently performed from above downwards, by the nurse is frequently effective, either by means of suggestion or from the fact that it tends to assist the cerebral anæmia which is necessary for quiet sleep. Many cases benefit from sleeping in the open-air.

States of Depression.—The treatment of depressed

cases is on the whole productive of success in a fair proportion of the total. An acutely depressed patient must be treated in bed; no ideas of "brightening him up" or "taking him out of himself" are to be tolerated for an instant. The necessity for rest is just as urgent as in a case of failing compensation or pneumonia, and bed, preferably in the open air, is the first essential. Attention to all excretory organs should be the first medical care—regulation of action of bowels, kidneys, and skin. Practically all states of mental depression are accompanied by constipation, and this in its turn aggravates the mental state unless actively treated. Different aperients suit different patients, but in many cases very much smaller doses will be found to be necessary if the aperient is given combined with a course of Liquid Paraffin, which appears to supply the necessary lubrication of the gut which is lacking. In the same way the amount of urine passed is diminished in quantity when the case first comes under treatment. The skin does not act at all freely without medical assistance. After attention to the above-mentioned functions, the next step is to ensure the fact that the patient assimilates sufficient food. A generous but plain diet, with the addition of extra fats, should be given, but it is not sufficient to know that the patient takes all that is ordered for him; he must be carefully observed to make certain that the food is being assimilated. No good will be derived from overfeeding a patient who is already suffering from dyspepsia, and in many cases it is necessary to change the dietary and times of administration repeatedly, before one which suits the individual is found. Many of these cases evince considerable reluctance to take food, and if, when a meal is served, the case is noticed to require hand-feeding, owing to active resistance, tube-feeding

should be at once instituted. Considerably more harm is done by delaying tube-feeding until the patient has begun to lose weight and strength, than by starting immediately signs of definite refusal are noticed. All cases of depression should have attention directed as early as possible to the condition of the mouth—foul, useless stumps should be removed, and a regular oral toilette maintained. This procedure alone will restore normal appetite to a considerable proportion of depressed and miserable patients. Drug treatment should be, so far as possible, restricted to tonic mixtures, but if sufficient sleep is not being obtained, the administration of a small dose of sedative before the usual hour of retiring should be practised. If possible, morphia or opium preparations, which tend to increase the already troublesome constipation, should be avoided; but this cannot always be done, as in cases of severe agitated melancholia, morphia is frequently the drug which produces the most immediate benefit. *Cannabis Indica* is another drug from which some patients derive more relief than from anything else, and it should always be tried if other hypnotics fail in producing a satisfactory result. But the induction of sleep by means of sedatives should not be sanctioned until other methods have been exhaustively tried, unless the need for sleep is urgent. All cases of depression require to be considered from the point of view of self-destruction. Is the patient suicidal, actively or probably, impulsively or designedly? Whenever there is any ground for doubt, the patient should be regarded as actively suicidal, at any rate for a month or so, until his mental state and habits are well known. The precautions to be taken in suicidal cases are more fully described elsewhere, but it may here be insisted upon that the precautions ordered on the

"Suicidal Caution" or parchment, as printed in the chapter on suicidal patients, must be carried out to the letter and no slackening must ever be permitted. When a case arises where it is considered that more exercise and liberty should be extended in the interests of the patient, the parchment should be definitely cancelled. The best indications of a good prognosis are undisturbed sleep and a rise in the body-weight. Increase of weight, with no obvious mental improvement, however, is an ominous sign, and frequently the earliest symptom of progression towards a state of chronic mental disorder. As soon as signs of recovery manifest themselves, the patient should be allowed up, at first only for an hour or so, then for increasingly long periods, and the taking of exercise, which must be gradually increased, should be fully encouraged.

Employment should not, as a rule, be provided unless the patient himself expresses a desire for it, and then, if possible, it should take some form dissimilar to his ordinary habit and preferably in the open air. During the whole period of his stay in the hospital, his weight must be kept under review, and any tendency towards loss should be the signal for a complete physical overhaul. The generally depressed metabolism of these patients, with their feeble cardiac action, shallow respiration, and, in many cases, immobility, all tend to make them favourable subjects for tuberculosis, a fact which must always be borne in mind. Another point to which attention may be drawn is that many depressed cases, especially of the adolescent type, unless carefully treated, exhibit marked circulatory weakness in hands and feet, giving rise to a condition simulating Raynaud's Disease. The extremities become cold and cyanosed, and frequently small septic sores, resembling chilblains, but singularly difficult to heal, make

their appearance. The only form of treatment which gives satisfactory results is rest in bed, with the affected parts wrapped in cotton wool, and a course of calcium chloride or lactate. For the sores, if they have actually appeared, two fomentations, followed by careful drying and painting with Tr. Benzoini Co., will usually produce a satisfactory result.

Psycho-analysis in certain of these cases appears to be beneficial, but there will be many failures, and the constant reiteration by the medical officer whenever he sees the patient that he is looking better, and is going to get better, frequently appears to act as well as more elaborate forms of treatment by suggestion proper.

Visiting is, as a rule, harmful to such cases, and at any rate should be restricted, as also should letters, and no pressure must be put upon the patient to answer such as he may receive. It is necessary to impress on the friends over and over again that their appeals to the patient to "rouse himself" and "cheer up" only tend to aggravate his mental state, and frequently give rise to increased belief in the imaginary harm which he thinks he has done.

The question of alcohol in such persons is a debatable one, and one on which different authorities express widely divergent views. Stout is frequently a valuable adjuvant, not only to digestion, but also in the treatment of insomnia. Stimulation which may be necessary in cases debilitated by refusal of food before admission, can most conveniently be given in the form of brandy. As a general rule, however, these patients do not require alcohol with meals, and it should be given purely as a medicine and in medicinal doses.

The prolonged warm bath is at times useful in the case of agitated melancholics, but the risk of attempted suicide must be kept in mind, and for most depressed

cases this treatment has not proved so successful as with excited cases. The Turkish bath has produced good results in the earlier cases of acute depression, as well as in the semi-stuporose cases of dementia præcox, but probably a good deal of the improvement noted may be due to the massage. Douches of various kinds have from time to time been highly recommended in the treatment of the stuporose forms, but it is difficult to prevent the patient from developing the idea that this is some form of punitive treatment which is being inflicted on account of past wickedness.

Massage is distinctly beneficial, not only in promoting the improvement of muscular tone during the long periods of bed treatment which may be necessary, but also in the treatment of constipation, and as an aid to general nutrition.

The treatment of melancholia by an intensive course of thyroid is mentioned in another chapter, and should always be tried before a case is regarded as having passed into the chronic and irrecoverable class. A certain percentage derive very marked benefit from this treatment, but the greatest care and strictest supervision are necessary during its administration, special attention being directed to the state of the pulse.

Suicidal Patients.—When a patient is admitted, with a note in the certificate or statement, to the effect that he or she has attempted or threatened to commit suicide, the medical officer must immediately issue a linen or parchment sheet with these facts clearly stated upon it, and containing instructions to all staff with whom the patient comes in contact that he or she must be continually under supervision. This "parchment," as it is commonly called, must accompany the patient in the event of any change of ward, and it is the duty of the head nurse to see that any nurse on duty in a ward con-

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CAUTION AS TO SUICIDE

.....has a strong Suicidal tendency.

She has attempted to kill herself by.....

She has threatened to kill herself by .....
and must on no account be left alone, not even in W.C.'s, until this Order is withdrawn by one of the Medical Officers, after consulting the Medical Superintendent.

.....
Assistant Medical Officer.

TO THE CHARGE NURSE, WARD.....;.....;.....;

Who will be held responsible for the due carrying out of the following Orders:

1. That this Parchment accompanies the Patient if removed to another Ward.

2. That the Parchment hangs on a special clip.....

3. That all Attendants permanently attached to the Ward and the Night Attendant in charge of the Patient must read and sign the Parchment. Those, however, doing temporary duty, must, after reading this Notice and having the Patient pointed out to them, sign the Book specially kept for the purpose.

4. That the Parchment be laid out for inspection every.....
day, at the visit of the Medical Officer.

I have read and understand the above caution.

(*Signed*) Charge..... 5th.....

2nd..... 6th.....

3rd ..... 7th.....

4th ..... Night.....

COPY OF SPECIAL CARD,
Issued in the case of all suicidal patients.

taining suicidal patients is fully acquainted with the individual patients, and that they are handed over definitely from the care of one nurse to another. Space is provided on the card for each nurse who is attached to that ward to sign, stating that she has read the card and knows the patient. Any neglect of these regulations is a serious breach of discipline, and the medical officer who, under any circumstances, may find a "special" patient not under observation, should report the fact at once to his superintendent. The care of such patients is always a responsible one, and it is obvious that they must be confined as far as possible to certain wards, viz. those which have a posted night nurse and an open observation dormitory. Care must be taken to see that those who are fit to be up and about obtain sufficient exercise, if necessary on the arm of a nurse or attendant, and are not allowed to spend their time in the airing-court, sitting and shivering on a special seat, with a constantly changing succession of nurses to look after them. But the most difficult questions arise when the patient's condition demands that an effort be made to interest him or her in some form of employment, and here an intimate knowledge of the patient's state and progress is the only guide; it is very difficult to resist the plea of the patient, and probably the relatives as well, for some means of passing the time. Fortunately, these patients, when they evince a desire for employment, are usually beginning to clear mentally, and accidents are infrequent with patients on "special cards." The most common methods of suicide in mental hospitals are probably by hanging or strangulation, and such accidents occur more frequently among patients who have been resident for a long period, and who have never been recognised as requiring special supervision, than among those known to be actively suicidal.

Probably the most commonly selected of all places for suicidal attempts is the W.C. or lavatory. This fact is so well known that special precautions are taken not to afford any projecting cornice or looped pipes from which suspension could take place. Nevertheless, in the case of the determined suicide, the W.C. is one of the favourite sites for an attempt at self-destruction, and adequate supervision by the staff is here, as elsewhere, the only reliable safeguard.

The utmost care should be taken never to place a patient on a " parchment " unless one is convinced that the patient is *actively* suicidal, and parchments should be cancelled as early as possible, always with due regard to the patient's welfare, which is the one object to bear in mind. So long as the number of " parchments " in a hospital is kept within reason, the supervision is bound to be fairly good, but if an idea once gets abroad that a medical officer is in the habit of issuing parchments on inadequate grounds, the staff are likely to become careless in their supervision of such cases. The habit of issuing parchments for reasons other than suicide, e.g. escape, is in my opinion greatly to be deprecated.

As soon as it is decided that a particular parchment may be cancelled, and the sanction of the medical superintendent has been obtained, it is wise to see the patient and inform him or her of the fact, pointing out that this is the first step on the road to recovery, and that it will lead to the acquisition of considerably more liberty. If the patient is not yet employed, a further effort to interest him in some form or another of work should be made, stress being laid on the curative value of regular and congenial employment. It is wise, however, to keep the patient for some days longer in the ward, where he is well known to the staff, who are therefore more likely to discern any early

symptoms of relapse to his former state, if it should occur.

Periodically, one meets with cases who are determinedly suicidal to such an extent as to need special nursing night and day. Such patients will make desperate attempts at self-destruction by means of strangulation with their own hair, thrusting a fist into the mouth, twisting of the scrotum and testicles, gouging out the eyes, and such insane actions. The question of restraint will always need consideration in such cases, which are fortunately rare, but it is wise to use chemical restraint in the first instance. A full dose of hyoscyamine or hyoscine will usually deal with the situation for a time, during which period it may be possible to place the patient under the influence of sulphonal or other sedative. This acute suicidal tendency rarely persists for long, and usually after four or five days the sedative can be stopped or diminished, and the patient placed under the ordinary ward conditions.

The only real protection, however, which a mental hospital offers from suicide is the observation exercised by the staff. The modern hospital is usually built with all the ingenious appliances and devices which time and experience have suggested to obviate the risk of suicide, yet such accidents do occur from time to time, and probably always will, and the most important defence remains in observation and knowledge of the patient. At the same time, some of the more obvious precautions may be mentioned. If it is for any reason necessary that the patient should sleep in a single room, all bedding and clothing must be constructed of untearable material, no furniture must be allowed, and the chamber should be one made of gutta-percha. All the special cases in a ward should be fed at a separate table; it is obviously useless to cut up the patient's food and supply a

spoon with which to eat it, and seat him next to a patient who is allowed the ordinary knife and fork.

Many unusual forms of suicide are reported from time to time, e.g. a well-trusted patient on one occasion detached the india-rubber tube from a gas-ring, inserted it into a large paper bag, in which he had placed his head, fastened this round his neck with his tie, and turned on the gas. Attempted poisoning by eating shrubs is not rare, but suspension and strangulation are the most common, and also the drinking of such articles as ink and floor polish. Melancholics probably constitute the class of case which provides the greatest number of suicidal patients, and every acute melancholic is potentially suicidal. The most dangerous, however, are usually those who lapse into a chronic state of depression, sit about, never speak or endeavour to employ themselves. The supervision of these people from the very fact of their chronicity is liable to become lax, and one day an opportunity may occur. Delusional cases, especially those of obsessional type, may be very suicidal, e.g. the man who has had gonorrhœa in his youth, and now has a fixed idea that he has infected his wife and family and ruined them, and is therefore unfit to live.

Epileptics and general paralytics are rarely suicidal, but the latter may at times commit acts under the influence of grandiose ideas. A general paralytic may precipitate himself in the belief that he is the most marvellous jumper in the world.

A troublesome class of case in this respect is the mental defective, with hysterical manifestations, who, on being reproved for some minor breach of discipline, proceeds at once to the W.C. and fastens a boot-lace or strip of petticoat round his or her neck. Treatment by moral suasion, the stopping for a time of all privileges and entertainments, refusal to

allow the patient to continue in the usual employment, and confinement to a particular settee in the ward, as a rule work wonders in such cases, but only for a time, when the same thing again takes place. Whilst recognising that this form of suicidal attempt is not genuine, one has always the haunting fear that the patient may on one occasion go further than he or she actually intends. In dementia præcox suicide is not common, but is seen at times in the paranoidal variety, when the patient's ideas of persecution become unbearable.

In conclusion, it may be repeated that in spite of all mechanical devices to prevent self-destruction, the best protection that the patient has, lies in the medical officer's knowledge of the mental state of his case and the supervision exercised by the ward staff ; no patient should be placed on a parchment without good and sufficient reason, and no parchment cancelled without due consideration, not only of the mental state as estimated by oneself, but also of the report of the charge nurse of the ward. If possible, no ward should ever contain more than six parchments, as this is probably the greatest number that can adequately be supervised without hindrance to the normal work of the ward.

Every patient who is on a suicidal parchment should be stripped absolutely naked before being allowed to don his night attire, and the staff must be warned carefully to observe him at the time of undressing to ensure the fact that he cannot conceal any weapon or substance with which to injure himself during the night. A patient has been known to mutilate himself severely with a pen-nib. One moment's inattention or carelessness may lead to tragedy, and this fact cannot be impressed too strongly on the staff.

In Ward-gardens.—It should be mentioned again

that the greatest care must be taken to see that such suicidal patients as are fit to be allowed out in the airing-courts obtain sufficient exercise. Unless attention is specifically directed to this point, there is a distinct risk that these patients will be kept confined to a special seat in the airing-court under the charge of a nurse. The charge of the court should be instructed that such staff as are not on "posts" in the court must take one or more "specials" to walk round the court with them, changing their patients from time to time. The same instructions should be issued with regard to the stuporose primary dements, who would otherwise stand about, with cold extremities, and derive actual harm instead of benefit from their exposure to the air.

I make no apology for having dealt with the subject of suicidal patients at length, as it is one of the greatest importance to the medical officer, and it is a direct responsibility of his to see that all suicidal patients are kept under proper supervision and at the same time receive the attention necessary to advance their recovery. All the efforts of the nursing staff will not compensate for a lack of knowledge on the part of the medical officer or a failure to use his knowledge in regard to the all-important subject of the classification of his patients.

Homicidal Patients.—From time to time this class of patient is seen, and may give rise to a great deal of trouble and a number of casualties. Fortunately, a persistently homicidal man is rare, but impulsive attacks by an epileptic or a delusional case are more frequent. When once a patient is known to have had an impulse of this nature, he should be cared for in an acute ward, where there is never any shortage of staff, in addition to the employment of any form of treatment that the medical officer may deem advisable in the particular case. As in all

insane actions, an effort should be made to discover, if possible, the patient's reasons for such. In delusional patients this can usually be elicited, but many epileptics have no recollection of such actions immediately they are past, and so are unable to describe or account for them. In the event of a patient taking a fixed and unreasoning dislike to any member of the staff, he should, if possible, be removed to another ward, but if the dislike and aggressiveness persist, and especially if the object of his hatred be an officer who has constantly to visit him, the medical superintendent should be consulted with a view to the patient's transfer to another hospital. Needless to say, no patient of this type should ever be employed in any way except perhaps in such work as hair-picking; if allowed to do ward work, he has opportunities of doing damage with the ordinary cleaning utensils, brooms, buckets, etc. Special supervision must also be given during meals, and it may be necessary to feed him at a separate table.

CHAPTER VII

TREATMENT OF SPECIAL MENTAL STATES (contd.)

Epileptic Patients—Imbeciles—General Paralytics.

Epileptic Patients.—Experience has shown that the insane epileptic is happier and more amenable when treated in wards confined to epileptics alone than when in mixed wards. Among the most common symptoms of the insane epileptic are irritability, and readiness to misconstrue the actions of others, and to fabricate complaints of ill-usage or bad treatment, and there is no class of patient with whom prolonged contact is more trying, or in whose case individual attention gives better results. The routine treatment of all epileptics with bromide is happily a thing of the past, but one form of regular treatment should always receive the careful attention of the medical officer, and that is the administration at least twice weekly of an aperient. In most cases these patients are very ready to take medicine, and a large number of them soon realise that the regular action of the bowels has a most important bearing on their epilepsy.

With regard to sedative treatment, bromides are still the sheet anchor of the practitioner, but should not be prescribed unless there is a definite indication. The particular combination of drugs, dosage, and time of administration, should be laid down for each individual case, and the effect upon both mental

and epileptic states most carefully observed for the first few weeks. It is usually wise then to stop the medicine entirely for some days in an endeavour accurately to ascertain what amount of benefit, if any, has been derived. If the results have been unsatisfactory, the question arises as to the substitution of a different mixture or of suspending sedative treatment entirely, and many chronically insane epileptics require such treatment only when acute excitement, a succession of fits, or some such emergency arises. The drugs which are most commonly used are as follows : Bromides of Ammonium, Sodium, Potassium and Strontium (usually in combination with Liq. Arsenicalis ♏. ij or iij), Borax, Valerianate of Zinc, Digitalis, Belladonna, Hyoscyamus, and Chloral Hydrate.

Some authors have advocated heroic dosage by bromides, but it is rare that benefit is seen from the administration of a larger dose than grs. lx in the twenty-four hours ; and with regard to chloral hydrate, the author is of opinion that it is unwise to administer this drug except when the patient is in bed, and going to remain there for at least a couple of days after the administration of the last dose, as cases of severe syncopal attacks are only too frequent if the patient is allowed to be up and about during the administration of the drug.

Every book treating of epilepsy is insistent on the necessity for looking for causes of peripheral irritation, such as errors of refraction, morbus cordis, dyspepsia, etc., but enough importance hardly seems to have been attached to dental conditions. Over and over again it will be found that even the ordinary destructive dentistry exercised in clearing the mouth of stumps and teeth, decayed beyond repair, produces remarkable results, not only on the patient's physical state, but also in the number and frequency of fits

and the accompanying mental symptoms. It is admitted that this is not a pleasant task for a medical man, but until all mental hospitals have a dentist added to the staff, it is part of his work and of the utmost importance to the patient.[1]

Status Epilepticus.—In the event of status epilepticus occurring, the first order given should be for the administration of a large soap and water enema. As soon as the evacuation of this is complete, gr. xxx āā Pot. Brom. and Chlor. Hyd. in a small quantity of warm water should be given per rectum, and this dose can be safely repeated at quite short intervals if the fits are not controlled. The three medical superintendents under whom the author has served are unanimous in stating that they have never seen a case of status which required to be anæsthetised.

Many forms of diet have been tried at one time and another for these patients, mostly with a view to reducing the amount of nitrogenous food, but without any markedly beneficial results, and in most of the large hospitals the epileptic wards are on the same diet scale as the others, but the substitution of semi-solid or liquid diets in the case of edentulous patients, those who are actually at the time "fitty," and such as are known to have a tendency to bolt food, is most important. In cases of choking in an epileptic, it is practically impossible to say whether the choking caused the fit, or the onset of the fit was the cause of the choking, but every precaution which will minimise the chance of such emergency should be taken. Some observers report beneficial results from prohibiting or diminishing the supply of salt at the ordinary meals, but in my hands the results have been nil.

[1] I am glad to say that since the above sentence was written the L.C.C. have appointed dentists to all their mental hospitals.

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In the periods of acute excitement from which some epileptics suffer at regular intervals, the first thing to do is to put the patient to bed in a single room or padded room in the ordinary bedding, unless there is any reason for strong rugs, and to *administer a brisk aperient*, this being one of the occasions when croton oil is extremely efficacious. If the noise and excitement are so acute as to render the patient dangerous to himself or others, or if his condition is giving rise to restlessness and excitement in the ward, it may be necessary to give a hypodermic (Hyoscine $\frac{1}{100}$ gr., Morphia $\frac{1}{4}$ gr., Atropine $\frac{1}{150}$ gr.) and seclude him for a short period. If the condition does not respond to this form of treatment in twelve hours, the patient should be placed on substituted diet, and a course of sedative by the mouth instituted.

The treatment of these cases by hot baths has not been a success, and the above-mentioned methods are more satisfactory.

A brief reference must here be made to "Masked Epilepsy" or Epilepsie Larvée. This condition consists of various forms of mental disorder which occur without any connection with seizures (major or minor). The patient who suffers from this particular form of the disorder may for days exhibit any of the well-known forms of mental disease. Automatism and double consciousness are both seen, and the condition is one of great importance from the medico-legal point of view—unprovoked assaults or even murder, sudden disappearance and unnatural offences, frequently occurring in this disease, and its existence must always be borne in mind, especially if any question of the patient's discharge arises.

In some epileptics a marked periodicity is observed —an attack of furious excitement, a succession of fits, or some similar manifestation, taking place at more or less regular intervals; and in women

the monthly period sometimes appears to bear a marked relationship to the acute phase. Trouble of various kinds can in these cases be avoided by seeing that the patient is kept in bed for some days previous to the date at which the period is expected to commence.

A considerable number of these patients, especially of the imbecile type, are quite good workers and desirous of employment. The question arises as to the safety of various forms of employment, both from the point of view of the patient and the staff. It is unwise to employ any patient who has given evidence of automatism outside the ward, and the form of employment should always be one where the supervision is constant. Employment outside the ward should never be permitted until the patient's epileptic habit and type are both thoroughly well known.

In the case of male patients who have exhibited no sign of violence or automatism, employment in their own trades may, as a rule, be encouraged, with certain reservations which common sense will dictate, e.g. a patient who is a painter and decorator should on no account be allowed on a ladder or platform.

In many hospitals, female epileptics are not allowed in the laundry on account of the supposed danger from machinery, whilst in other hospitals it is permitted by the medical superintendent, and the medical officer should never employ a patient in such work without having assured himself that it is not opposed to the practice in vogue.

When male patients are employed on the farm or grounds, care should be taken to see that those who work with him are aware of his liability to seizures, and also that he is not allowed to work with cattle or stock of any kind. Careful selection is necessary in all trades where sharp implements are in common

use, e.g. shoe-making, carpentry, etc., as one does not care to consider the consequences of a state of furor in a patient armed with a shoemaker's knife; in fact, employment of epileptics is a shining example of the necessity for accurate knowledge of the individual patient.

It is a frequent custom to issue, on the admission of a patient known to be epileptic, a card, with the word EPILEPTIC printed on it, and a chart showing each day separately. The first ensures that in the case of the patient's removal, there is no possibility of the fact that he is an epileptic being overlooked, and the second that an accurate record of the incidence, periodicity, and nature of the fits (major or minor) is kept.

The question of recommending the discharge of epileptic patients is one which is full of difficulty. A certain number of these patients improve mentally and physically under hospital conditions, and the relatives, noticing this, and possibly being well aware of the fact that the patient is regularly employed, may press for discharge. The points to be considered are, firstly, the safety of the general public; any history of violence or of acute periods of excitement would at once raise doubts as to the advisability of such a person being at large. Similarly, with the feeble-minded epileptic who has shown sexual proclivities, one would need to be very definitely assured of the amount of supervision possible in the home before recommending the case to the medical superintendent. On the whole, the prognosis of the insane epileptic is bad. Many of them live long and fairly happy lives, but the number who recover sufficiently to be able to stay outside an institution is very small.

Epileptics, as a whole, are extremely religious people, and desire to be the most regular attendants at divine service, but it is necessary for a considerable

amount of supervision to be exercised with regard to this. They should not be allowed to attend when "fitty" or excitable, and they may be a nuisance to others on account of the vociferous manner in which they join in responses and hymns. In any case, they should be accommodated at the back of the chapel, and attended by members of the staff who are accustomed to deal with them, so that in the event of a fit occurring, the patient may be removed without disturbance to the rest of the congregation.

A point of importance in the ward discipline of epileptics is the arrangement for patients to avail themselves of lavatory accommodation. When a patient is in the W.C., a nurse must be at hand in case of need, and it will be found convenient to have fixed hours for the W.C.'s to be unlocked, so that a nurse may be posted at the door. Twenty minutes before and after each meal, and half an hour before bed-time, will usually suffice when the patients become used to the routine. It is undesirable to risk a patient visiting the W.C. without being observed, and possibly having a fit with nobody to help. Similarly, whilst in the airing-court, one nurse should be posted at the entrance to the W.C.

Another question which from time to time arises is the period at which a patient may be regarded as having ceased to be an epileptic, and therefore possibly suitable for treatment in a ward without constant supervision. The answer to this question varies with different observers, and the medical officer should make himself conversant with the views of his own medical superintendent before acting in this matter. Generally speaking, a period of three years without a fit should entitle the patient to the benefit of a trial in another type of ward, but even after a period of this length the fits may recur.

There are certain patients who, when they have

a fit, almost invariably fall in a particular manner and attitude, and in some of these, severe casualties frequently occur in the same anatomical situation. This is particularly so with regard to scalp wounds. From time to time one sees unfortunate patients who have masses of scar tissue on the forehead or back of the head. Most patients fall forwards, and, whilst it is not possible always to prevent such accidents, a good deal can be done by fitting these cases with a close-fitting cap or sun-bonnet, with a firm pad encircling the head. It may be difficult to induce the patient to wear such an article, but persuasion will, as a rule, be effectual, and the patient soon appreciates the protection from injury thus afforded.

Imbeciles.—This class of case, which under the provisions of the Mental Deficiency Act should become less common in county mental hospitals, is one which requires a considerable amount of attention in order to obtain the best results. Whilst an imbecile is naturally a case in which recovery cannot be hoped for, still, in many cases, a vast improvement can be effected in mental condition and ability to be useful to the community.

The discipline, regular food, sleep, and life generally of the institution, practically always have a beneficial effect on imbeciles. They are simply overgrown children, who in some cases display childish characteristics which are unpleasant and objectionable because the patient is an adult. As an example of what is meant, one need only refer to the destructiveness of a child which is dealt with by education. In the same way, the imbecile who smashes cups or destroys clothing can be educated in many cases to restrain himself from such behaviour. These patients are childish, vain, self-conscious, and very jealous. They appreciate notice being taken of them, and a word of praise for a flight of stairs well scrubbed or

a tin highly polished, produces a degree of pleasure in some defectives which must be seen to be believed. They are frequently extremely imitative—a characteristic of which great use may be made in training them in some trade or handicraft, but it must be remembered that very few of them, even when they are good and productive workers in a hospital, are capable of fighting their own battles in the outside world.

Faulty habits must be coped with in the usual way; if possible, regular habits with regard to visiting the lavatory should be the first thing to aim at. Following this, an effort should be made to convince the patient of cause and effect—that the reason he cannot attend the patients' dance is, say, because he is wet. In robust healthy cases the necessary cleansing may be carried out with cold water, but only on direct medical order—the tonic effect of this being frequently as marked as that on the general muscular tone.

Masturbation in either sex is one of the most difficult habits to control, and it may be said at once that any treatment, such as blistering or the wearing of some apparatus, only directs the patient's attention to the sexual organs and is foredoomed to failure. Improvement in bodily health, regular open-air exercise, if possible to the stage of mild fatigue, a hard unyielding mattress and pillow, with, in the early stages of treatment, a small dose of potassium bromide at bed-time, and special care to see that the bladder and rectum are empty when the patient retires to bed, are the forms of treatment which hold out the best prospects of cure in this habit.

Whilst in the majority of these cases the faculty of attention is extremely defective, yet many of them are capable of useful work under supervision. Train-

ing in some simple mechanical employment may be long and tedious, yet by exciting the imitative faculties much can be done. Most mental hospitals can show a large number of such cases usefully and regularly employed in the various shops, e.g. boot-making, tailoring, basket and mat-making and upholstering, and on the female side in the laundry, work-rooms, kitchens, and wards. As has been previously mentioned, a system of rewards and privileges, such as country walks, dances, and entertainments, judiciously employed, will frequently stimulate apparently hopeless imbeciles to endeavour, and once this is attained, the rest is dependent on the patience and labour of the staff. A form of treatment which is useful from both mental and physical standpoints, is simple physical drill, which is just as desirable on the female side of the institution as on the male. Many of these cases are very poor specimens physically, with stigmata of degeneration, poorly developed chests, etc., and obviously presenting a fertile soil for the tubercle bacillus. The benefit derived from regular drill carried out, if possible, in the open air, under the instruction of an attendant, who should be, if possible, an ex-service man, is remarkable. Here again, if a few of the best behaved imbeciles can be formed into a class and drilled in front of other defectives, the imitative instinct is readily aroused, and the class usually grows rapidly in number, especially, it may be said, if their own medical officer takes an interest in it. At first nothing but marching and the simplest rhythmical exercises should be attempted (preferably with the help of a piano, as many of these people have an acute ear for music); and then, as proficiency arrives, it may be found practicable to introduce such refinements as bar bells and Indian clubs, etc. Open-air games of every kind should be encouraged in the

hours devoted to exercise, but it must always be remembered that many feeble-minded cases have short and uncontrollable tempers, and, therefore, it is desirable to have members of the staff who know the patients associated with the various games.

In cases of imbecility combined with epilepsy, no marked improvement can be expected. These cases go progressively downhill mentally and physically, and it is extremely difficult even to establish habits of cleanliness. Treatment should be undertaken at once with a view to controlling, so far as possible, the seizures, but in this connection it must be remembered that the prolonged use of bromides, or other sedatives, has in itself a deleterious effect upon the brain cell. Careful observation must be kept also for any progressive loss of weight, night sweating, etc., as these particular cases are very prone to develop tubercle, and this is one of the points of which it is as well to warn the relatives. Frequently, as soon as an imbecile begins to improve under the regular life and discipline of the hospital, the relatives begin to agitate for his discharge. If the home is a good one, and evidence is forthcoming that supervision can be exercised, it is difficult to refuse such applications; but the parents, having failed to manage the case before, will probably do so again, and the patient eventually returns with all the previous improvement undone and the old habits re-established. The chances of an imbecile are on the whole better from the point of view of employment, in rural rather than in urban districts, and this must be taken into consideration; but, after all, it is only the high-grade ament who is capable of earning a living at all, and it is not productive of economy to the rate-payer if the patient produces several smaller editions of himself.

Possibly some kind of colony treatment is the best for these cases, where they can be cared for and

employed with the necessary control and supervision and at the minimum expense. Special forms of treatment, apart from those already mentioned, are not commonly needed in the cases of imbeciles, but the physical condition should be reviewed in the ordinary way when the patient's monthly weighing takes place.

General Paralysis.—Whilst it is not proposed in any way to discuss the differential diagnosis of general paralysis, it may be advisable to draw attention to the absolute necessity, if not in all cases, at any rate in all doubtful ones, for the employment of the Wassermann reaction, and the examination of the cerebro-spinal fluid.

Once the diagnosis is established, the patient should never sleep outside an observation ward, as it is quite impossible to foretell the occurrence of seizures. It is common to keep, so far as possible, G.P.s who have reached the stage of needing infirmary care to a special infirmary, when the following points must be noted.

Diet.—Except in the very early stages of the disease, it is certainly safer to confine these patients to slop food, such as " wet mince," porridge and milk, etc., as they are mostly ravenous eaters, and likely to choke.

No G.P. should ever be allowed to retain any artificial denture, as, in addition to the above-mentioned dangers whilst feeding, the teeth may give a great deal of trouble during seizures. For a varying time before death it is essential to put these patients on liquids only, and even then feeding must be carefully carried out.

Liability to Injury.—It is well known that G.P.s, especially in the later stages of their disease, are peculiarly liable to sustain fractures of bones from trivial causes, this undoubtedly resulting from de-

generative changes in the substance of the bones themselves.

Opinion varies as to the necessity for the employment of low bedsteads, but even with the most skilful nursing, an occasional fall from bed may occur, and the lessened distance must of necessity minimise the risk.

Various types of patent bedsteads have from time to time been recommended, such as the so-called "Cushion-bed," where the wire mattress, upon which the patient is supported, is considerably lower than the sides of the bed, these sides being also made of wire, protected by rubber. The idea is to prevent the patient from rolling on to the floor by means of a partition against which it is impossible for him to sustain any injury. Few of these devices have met with much favour, most authorities considering that the safety of the general paralytic depends more upon the constant supervision exercised over him than on any mechanical device.

Employment.—If the patient expresses a wish for work, and on being given a trial proves his ability to perform it satisfactorily, there is no objection usually raised, but the necessity for constant supervision is just as important as in the case of epileptics, with the additional danger of the special liability of the G.P. to injury. On the whole, if employment can be found in the ward, it is probably better to confine the case to work therein.

Liability to Diarrhœa.—These cases are very subject to sudden attacks of diarrhœa for some reason, and particular attention must be directed to the necessity of at once treating any bowel irregularity, as constipation increases the liability to excitement, restlessness, and noisiness.

Unexplained Rises of Temperature.—From time to time, one's attention is drawn to a general

paralytic who appears to be in his usual state, but who has been found to have a marked rise of temperature. Examination reveals nothing, and the temperature, after remaining high for a variable time, returns to normal without the patient suffering in any way. It has been suggested that these fleeting attacks of fever are due to some interference with the heat-regulating centre. On the other hand, however, a sudden rise of temperature may be premonitory of a seizure. These convulsive attacks frequently usher in the final stage of the disease, and active treatment should be undertaken at once. A large enema is commonly sufficient to cut short the attack, but if not, chloral and bromide by the rectum and a drop of croton oil by the mouth should be given. If the patient rallies from the seizure, it will generally be found that a certain amount of palsy is present, which passes away in a few days. Paralysis of a similar kind is often seen in cases in whom, although under constant observation, no seizure has been observed.

Bed Sores.—It is always wise to place a patient who has had a seizure in bed in a padded room, if possible, on liquid food, and direct special attention to bowels and bladder, as retention is common. A complete examination should be made of any patient who has had a seizure. He should not be confined to bed permanently until it is absolutely essential to do so on the ground of general feebleness, as these cases are most difficult to keep free from bed sores. Should such develop, they must first of all be rendered, so far as possible, clean with a few fomentations. Subsequent dressing with an ambrine candle is a satisfactory form of treatment.

Treatment by anti-specifics (Hg., K.I., or by 606, or any of the more modern substitutes) produces no benefit, and some observers state definitely that they

consider the case is frequently made worse by such treatment.

Discharge.—All general paralytics are liable to remissions of varying length, and it sometimes happens that the relatives become importunate in their demands for the patient's release, but this can rarely be justified. The certainty of relapse, and the risk of sexual troubles which need not be particularised, are two of the most obvious objections.

Tube Feeding.—If at any time it is necessary to feed a general paralytic by tube, the œsophageal method is preferable to the nasal on account of the reflex impairment, and the tube should be guided by the finger past the epiglottis and into the œsophagus.

These cases rarely give trouble from excitement or noise, but occasionally an acute attack of mania is seen in the course of the disease. This must, of course, be treated on ordinary lines and at once, as, unless controlled, the patient is only too likely to sustain some injury: a hypodermic of hyoscine, followed in an hour's time by a dose of paraldehyde and sulphonal, plus an active aperient, will usually control such cases, but the additional safety of a padded room is desirable.

CHAPTER VIII

PATIENTS OF DEFECTIVE HABITS

Spitting—Faulty Habits—Masturbation—Persistent Removal of Clothing—Destructiveness—Self-mutilation—Rubbish Hoarding—Filth Eating.

Spitting.—In some insane patients a troublesome and very intractable habit is that of spitting about the ward indiscriminately. Apart from the unpleasant nature of the habit, and the danger that may be present of infection, there is the risk of another patient taking the law into his own hands and violently assaulting the offender. As in all insane habits, the first step should be a prolonged and careful examination directed to finding, if possible, the cause of such behaviour. If due to delusion, e.g. poisoning, the treatment must be directed to distracting the attention from this belief, or endeavouring, by prolonged argument and reasoning, to upset it. If both of these methods fail, it may be possible, by patience and firmness, to induce the patient to make use of a spit-cup; failing this, it is worth while trying the method of keeping the patient apart from his fellows in the ward or airing-court. But some of these cases will defeat every effort, and remain during the whole of their lives a source of danger and discomfort to the hospital community; they must, at any rate, be kept from associated entertainments and amusements, and, so far as is possible, kept to their own wards and airing-courts.

In patients who are confined to bed, and who

persistently spit about the room in spite of treatment, it is frequently of service to make a pillow-case of jaconet and use a mackintosh sheet instead of a counterpane. One or more mackintoshes spread on the floor may also be useful, as they can be readily washed. Treatment directed towards diminishing the flow of saliva, such as the administration of belladonna, is rarely of any value in stopping this habit, and has other disadvantages which militate against its usefulness.

Faulty Habits.—With regard to the habits generally reported as "wet and dirty," it must be remembered that the cause of such varies in different types of insanity, e.g. in general paralysis of the insane the loss of control is physical, in dementia præcox purely mental. But in all cases the first step to take is to endeavour to establish regular habits in regard to visits paid to the W.C. All such cases should be taken to the closet on rising, after each meal, and the last thing before retiring to bed. In this the medical officer is entirely dependent on the care and trouble taken by the ward staff, but this may, as a rule, be ensured by instilling into them the fact that the more carefully this routine is carried out, the less trouble the patient gives and the better chance he has of complete recovery. Every care must be taken to assist the normal action of the excretory organs in each individual patient by attention to diet and such medical measures as may be considered necessary; in many cases it will be found advisable to give nothing to drink after tea. In cases where the habit appears to be definitely due to any form of hysteria, lack of sympathy, and a somewhat harsh line of treatment with regard to raisingthe patient at night, limitation of fluids given, and curtailment of privileges and amusements, are frequently productive of good results, especially if combined with some degree of suggestion

on the part of the physician. In a number of cases, however, this habit cannot be cured, and the comfort and health of the patient rest with the constant supervision which it is the duty of the hospital staff to supply. In certain cases attention to the patient's general health is productive of some result, and in all new cases who are sufferers from this condition, particular attention should be paid to the bodily state as a whole in addition to excluding local causes.

In this connection it is very important to note that bed sores are very easily produced among such cases, even if the patient is not confined to bed more than the ordinary amount, unless the night staff are especially vigilant. Bed sores usually mean bad nursing, and any threatening of such a condition should be made the subject of immediate inquiry by the medical officer.

Masturbation.—This habit, prevalent amongst the insane, is more noticeable on the male side of the house, and probably on the whole more common, but its occurrence amongst female patients must not be overlooked.

In young male patients it is a source of constant trouble, and the point may be made that it is distinctly infectious, that is to say, that one persistent and open masturbator may and frequently does lead to an increase in the habit amongst other young patients in the ward. Treatment should be along general lines, local remedies having proved useless in the hands of practically everybody who has tried them. Manual labour to the extent of fatigue during the day, a hard mattress and pillow, the minimum of bedding consistent with warmth, and a cold shower or plunge in the morning, followed by vigorous friction, hold out the best prospects of improvement, but the habit is an extremely difficult one to break, and the patients frequently relapse.

The possibility of the habit having arisen from the irritation caused by phimosis should always be remembered, and circumcision is frequently a wise step even if the foreskin is not unduly contracted.

In female patients the habit has frequently, it is sad to say, been acquired at school, and either continued in later life or been re-established during the onset of the mental illness. It may take the form simply of digital excitation of the sexual organs, or in some cases an actual instrument made of rags or even newspaper may be used, and many of the cases practising self-abuse are absolutely shameless. The same forms of general treatment should be adopted, and every device to ensure deep sleep at night must be employed as in the male sex.

Particular attention is to be given to the rectum and bladder, as any cause of congestion or irritation in these organs is likely to stimulate the habit. Psycho-analysis has been extensively tried as also suggestion, but the results have not been good, and in many cases the reawakening of old sexual memories has proved to be very definitely harmful. Taken generally, it may be said that this habit is to a great extent a symptom of insanity, and not a cause, as was formerly widely believed. In itself it argues defective control of the emotions, and although all masturbators are not insane, the habit in a certified lunatic is certainly confirmatory of his or her mental state. As might be expected, it is most noticeable in adolescent cases, of the imbecile or primary dement type, but it also occurs in seniles, both male and female, and is then extremely intractable ; as a brief symptom it may give trouble in some few general paralytics.

Persistent Removal of Clothing.—When a patient persists in undressing himself or herself, as sometimes occurs, if no reason can be elicited and the case cannot

be dealt with by general control, it becomes necessary to take other steps. The habit is frequently based on a desire to get back to bed, and this, if possible, should be prevented. In women a "strong" frock securely laced down the back, and in men a combination similarly fastened, will usually deal with the habit satisfactorily; if, however, this fails, it may be necessary to resort to a course of sedative treatment.

Destructiveness. — This particular disorder of conduct varies greatly in degree in different cases, and also in the particular form which it takes. Some patients who are always tidy are persistent smashers of glass or crockery, whilst others confine their destructive habits to their own clothing and bedding. Here, as in other habits, a careful mental examination should be undertaken to elucidate, if possible, the reason for the abnormality. It is unnecessary to enumerate the many reasons which may appear adequate to a disordered mind for the performance of such actions, but in some cases the medical officer can influence the patient by argument and reasoning. No good results are, as a rule, obtained by such palliative measures as supplying the patient with rags to tear instead of his bedding—and in many cases they seem to act as a stimulus. If persistent in such behaviour, the patient should be clothed and bedded in some substance of the untearable nature supplied for the purpose, and frequently the fact that in this he is conspicuous and different from his fellows is productive of good. With such people as smash windows, etc., the precautions which are obvious must be taken, but it frequently happens that these patients have periods of quiescence lasting for weeks or months, and then a sudden outburst occurs in which they may do a considerable amount of damage before being restrained. The condition may be seen in dementia præcox and

also in certain epileptics ; but in the latter it is, as a rule, easier to prevent, when once the relation of the habit to the fits is known.

Self-mutilation.—This, whilst in severe and grave forms luckily uncommon, is frequently seen in such minor habits as picking at the skin, pulling out the hair, or rubbing part of the body until it becomes inflamed and sore. Once a patient acquires a habit of this kind, it is extremely difficult to break him of it, and, therefore, active treatment should be undertaken the moment that the tendency is noticed. In certain cases it may be necessary to keep the patient under the influence of some sedative for days together, or even to supply a special nurse in order to prevent the habit from becoming established. Picking at the face, etc., in the belief that there are maggots or insects beneath the skin, is not uncommon, and such cases may in a very short time disfigure themselves markedly, to the great and natural distress of the relatives ; or the habit may have a definite relation to the sexual organs, and the patient may make violent efforts to castrate himself by torsion. Treatment by sedative is probably the most useful here, but must be pushed actively for some days, and then stopped in order to see whether the habit ceases. Particular attention should be directed to keeping the nails carefully trimmed.

Some general paralytics show this habit extremely well marked, also agitated melancholics and some primary dements.

Under this heading it may be appropriate to mention that from time to time, one has trouble from patients who acquire the habit of inserting foreign bodies into the various orifices of the body. This habit is frequently not discovered until the action gives rise to some trouble, e.g. retention of urine due

to a stone in the urethra, or a vaginal discharge owing to a bone or piece of wood in the vagina. Once a patient is known to have developed a habit of this kind, orders must be given that he or she is to be treated as a special case for the time being, until there are grounds for believing that that particular idea has faded and is not likely to be reawakened.

Appropriate measures must be taken to deal with the condition as found, and this habit is only one more indication for an immediate and complete examination of any insane patient who presents a discharge of any kind whatever.

Rubbish Hoarding. — Some lunatics, chiefly dements, develop a habit of collecting and concealing, about their own persons for choice, quantities of useless articles, such as pieces of paper, stick, string, stones, old cardboard boxes, etc. In some cases this appears to be due to a perverted acquisitiveness; in others, to definite delusions as to values. It is not a habit in which the medical officer is able personally to exercise much control, but by constantly having such patients searched and "cleared out," he ensures that the habit can usually be kept within bounds. It may be asked, what harm is done by a patient hoarding half a dozen buttons? He may swallow them, he may sharpen one on a stone with intent to injure himself, he may supply one to another patient for the same purpose, or he may use the edge to turn the screw fastening a window sash. Regular and thorough searching is the only method of controlling the habit. It is extraordinary what discoveries will be made from time to time, and, unless it is done, the risk of emergencies is definitely increased.

Filth Eating.—Many patients, although possibly not such a large proportion as might be expected

are foul feeders, and it is necessary to indicate some of the more common lines along which this habit may develop. Paper, string, stones, wood, and cinders, in addition to excreta, are the more common objects which may be swallowed, and it will be seen that supervision is the only reliable prophylactic treatment. It will at times be necessary to place a confirmed rubbish-eater under the same strict supervision as a suicidal patient, but it is inadvisable to use the same kind of cautionary ticket for both classes of case. These patients are a constant source of anxiety, as they will swallow anything, floor polish, ink, and cleaning rags, upon which they can lay hands. As might be expected, from time to time abdominal conditions arise which excite some apprehension, but a case of perforation or obstruction appears to be rare from such a cause. Certain shrubs and trees are a source of danger to people of this type, particularly yew leaves. Horse chestnuts are also a favourite form of food with some dements, and the author has seen a case in considerable danger following a meal of golden privet. In the event of its being reported that a patient has consumed any poisonous substances, the necessary measures to empty the stomach and deal with such effects as may arise should be taken at once, but where there are grounds for believing that articles such as wire, bone, sticks or stones, have been swallowed, other steps are necessary. Observation in bed, with two days' feeding on milk, new bread, and porridge, followed by an olive oil enema, will usually ensure the safe passage of the offending substances, although surgical interference may of course be required.

Cases of volvulus, intussusception, and acute obstruction, have all been recorded as the result of swallowing various foreign bodies which might

normally have been expected to pass safely through the alimentary canal, such as leaves, straw, hair from a mattress, etc.

In conclusion, it should be remembered that the first warning that a patient has developed this particular habit may be given by the passage of a foul-smelling and bloody stool giving rise to a suspicion that he has contracted dysentery.

CHAPTER IX

ADMISSION OF NEW CASES

Notes—Eighth Day Statement—Case Taking—Correspondence—Letters from Relatives—Visitors—Illness Notices.

Summary of Medical Officer's Duties on admitting a Patient

Examine the reception order, medical certificate, etc., and see that the documents are complete, that the order is addressed to your asylum, and that the documents are all signed and correct as regards dates.

Examine the patient—as to his physical condition, particularly with regard to the presence, or absence, of any sign of bruising or injury, and as to his personal cleanliness, etc. Note the result of your examination *at the time*, and draw the attention of the relieving officer or other person bringing the patient to anything in the nature of injury, however slight.

The following notes are necessary:

One *after admission*, and before the end of the seventh day after admission.

Statement (for Board of Control) as to mental and bodily condition, usually written by Medical Superintendent.

Entry in case book as to mental and bodily condition.

Entries in medical journal—if under medical treatment.

2nd, 3rd, and 4th Weeks.—Entries in case book as to progress of case.

Entries in medical journals—if under medical treatment.

Thereafter as laid down in Rules of Commissioners of Board of Control.

Admission of New Patients.—Upon the arrival of a new patient at the hospital, the medical officer on duty for the day is notified. In the modern hospitals it is usual to admit all new cases into an acute block or villa, in which they stay until classified, and, in many cases, especially of acute mental illness, until recovery and discharge. The first duty which devolves upon the medical officer is to satisfy himself as to the correctness of the reception order which is the legal authority for the patient's detention.

It should here be noted that under the present Statute the responsibility for the proper reception of a patient belongs to the medical superintendent, whose representative in this matter the medical officer is.

In some hospitals the reception order is viséd by the clerk before it reaches the assistant medical officer, but it cannot be held that anyone but the medical superintendent is responsible.

It should be clearly understood that a patient is not technically "admitted" to a mental hospital until the order and certificate have been accepted as being in order.

Returns of the condition of the patient on admission handed to the relieving officer are not official, but would probably be held to be evidence of admission.

All this is of importance in view of the fact that patients have died in the reception room, before actual admission, and that they have occasionally been found to be suffering from contagious disorders without the latter having been definitely notified.

NOTICE TO GUARDIANS

State of .....

a Patient admitted into the above Asylum, on the.....

day of.....192 . *Reg. No.* .....

---

1. As to Cleanliness.....

.....

.....

.....

2. Bodily condition .....

.....

.....

.....

3. Position and description of any bruises, wounds, marks of injury, sores, skin eruptions, pain, tenderness, and evidence of any disease or disorder.....

.....

.....

.....

.....

.....

Medical Superintendent.

.....192

The Clerk to the Guardians.

.....

COPY OF NOTICE SENT TO GUARDIANS ON ADMISSION OF PATIENT

The patient's status under the Lunacy Act may be "pauper, private, or criminal," and the points to be observed in the certificates of the different classes are discussed in Chapter XII, as also those relating to service patients.

The documents, as soon as the medical officer is satisfied as to their validity, are sent to the clerk of the hospital. The medical officer then orders the removal of the patient to the ward, but before doing so it is necessary, if the patient is stated to be suicidal or epileptic, that this information be conveyed to the charge nurse. In the case of a female, the patient is stripped, weighed, measured, and put to bed in the presence of a head nurse, the charge nurse of the ward, and the relieving officer's female assistant, in order that all marks, bruises, signs of injury or disease, which will be pointed out to, or may be found by the medical officer, may also be seen by the representative of the Guardians; and this is particularly necessary in cases of scabies, pediculi, and any evidence of uncleanliness, as well as active disease of any kind, or injury. Fractured ribs are particularly likely to occur in the insane, and especially if the patient is a case of mania or a general paralytic with defect of sensation; such an injury may easily be missed unless the medical officer is on his guard, but if one rib is detected as being fractured, it is a practical certainty that more than one has received injury. Rupture of bladder or some hollow viscus is not so common, but is always to be borne in mind.

Pulmonary congestion, especially in old people, is frequent, and any signs suggestive of contagious disease must receive immediate attention, as, should any suspicion be aroused, the patient must be isolated, and the medical superintendent informed at once.

Having assured himself of the satisfactory physical state of the patient, which in cases of acute excite-

ment or resistiveness may be by no means an easy matter, the assistant medical officer must give orders as to the patient's disposal. It should be remembered that, with the exception of the facts in the reception papers, and such information as he may have gathered during his physical examination, the medical officer is so far ignorant of the patient's mental state, and in the majority of cases it is wise to send the patient to bed in the acute hospital, either in the ward or on a veranda. If, however, the patient is acutely excited and noisy, bed treatment in a padded room may seem advisable, not only from the point of view of the patient's safety, but also from the standpoint of others, and the question then arises as to the necessity for drugs. Unless, however, the excitement is very acute, it is frequently wise to wait until the evening round, as by that time the staff will have become better acquainted with the patient, and some indications as to treatment may be forthcoming. If it is necessary to quieten the patient, the choice is practically one between paraldehyde and one of the hyoscine or hyoscyamine salts. As previously stated, paraldehyde acts quickly, but is weak in its effect, and not lasting. If hyoscine or hyoscyamine be used in solution as a hypodermic, the solution must be one freshly prepared, but tabloids containing hyoscine, atropine, and morphine will be found to act quite satisfactorily; one or more can safely be given to a healthy patient, and the dose repeated, if necessary. Experience generally points to the fact that women can bear larger doses than men. An order for diet must be made out and sent to the stores: ordinary diet for the able-bodied and healthy patient, mince diet for edentulous senile cases or general paralytics, and milk for excited cases, or those about whom the relieving officer has stated that they refuse food. All newly admitted

patients should be ordered an aperient to be given at bedtime, and usually the ordinary house mixture will be sufficient; excited cases, however, may, and frequently do, exhibit signs that the intestinal metabolism is much at fault, and these cases almost invariably benefit from a full dose of calomel or from an enema. In the case of patients known to be epileptic or of suicidal tendencies, a card or parchment is issued so that all members of the staff who may have charge at any time of the patient are aware of these special facts. If the patient is found to be ill, or unduly feeble at the time of examination, an illness notice should at once be sent to the relatives or friends.

A certificate describing the condition of the patient on admission, and including a statement of all marks of injury or signs of disease noted by the medical officer, must be made out and signed by him before being handed to the relieving officer. If the patient is found to be suffering from any form of contagious disease, although the usual certificate of "freedom from infection" may accompany the reception order, the officer should be informed, and such parasites as pediculi, etc., actually demonstrated to him or his female assistant. Strictly speaking, the law entitles a superintendent to refuse admission to a patient suffering from contagious disease, should such disease, in his opinion, entail risk to his present patients; but other factors may need consideration here, and no one would be so unwise as to refuse admittance to an acute maniac because he or she had pediculi. In such cases the medical officer would use his own judgment, but any case in which he is suspicious of some grave disorder, e.g. one of the specific fevers, becomes one for the medical superintendent to be acquainted with at once.

A further point for the medical officer to settle at this time is as to the advisability of ordering the

——— MENTAL HOSPITAL

Height.....ft.....in.

Weight.....st.....lb.

No.....

Name.....Age .....

Union.....Occupation .....

State as to marriage.....Religious Persuasion .....

Subject to Epileptic Fits .....

Disposed to Self-injury, and how .....

Disposed to Injure Others....., of uncleanly habits .....

Any marked propensity .....

.....

Sent to Ward.....To have a warm bath (?) .....

To sleep in.....

Special Orders as to Diet, &c. .....

Placed in care of Attendant .....

Received.....Date .....

From .....

How long in Workhouse .....

All bruises, injuries, sores, evidences of disease of any kind, &c., to be reported *immediately* to one of the Medical Officers, and also to be entered in the Daily Report Sheet.

This paper to be shown to the Night Attendant before commencing duty for the Night, and if Patient be suicidal, special attention to be drawn to the fact.

Admission Notice

(Handed to Charge Nurse of Reception Ward)

patient to be bathed; if this has been done immediately previous to leaving the infirmary, it will usually not again be necessary. In the case of acutely maniacal patients, however, the question of ordering continuous baths must be considered forthwith.

All newly admitted patients should be seen both on the evening and night rounds, and information obtained from the ward staff as to the following points: temperature, pulse and respiration rate; refusal of, or reluctance to take food, or, on the other hand, ravenous eating; action of kidneys and bowels; violence, resistiveness, noisiness, and restlessness. The medical officer should give orders as to where the patient is to sleep and what further steps are to be taken in the event of insomnia or excitement.

Case Taking.—Whilst it is very necessary that the patient should be thoroughly examined on admission, it is frequently wise to confine this examination to the physical state, as it may be impossible to obtain an accurate estimate of the mental state in a patient who has had a considerable journey by cab or motor. It is often wise to let at least twenty-four hours elapse before proceeding to investigate the mental state. For this purpose the patient should be in bed in an examination room which is private, and only the medical officer and head nurse should be present. It is advisable to commence with another complete physical examination. This, whilst in itself possibly not strictly necessary, fixes in the patient's mind the fact that the examination is a medical one. When this is complete, and the facts have been entered on the case sheet, it is time to undertake the mental examination, and here it is quite impossible to lay down hard and fast rules as to procedure. The whole nature and extent of the mental disorder must of necessity be elicited in the course of conversation,

and whilst the medical officer may desire to direct this towards certain matters, the patient may obstinately refuse to assist him in so doing. Possibly the best general line to take is to commence with questions as to civil state, etc., passing thence to home life and employment. Then questions should follow as to the length of the illness, and the date on which the patient gave up work. In many cases, especially of the delusional type, the patient strenuously denies being ill, or having anything whatsoever the matter with him, in which case one can proceed to ask why he left home, who took him away, and where to? He should be asked if he knows where he is, how he came there, and when? Also, if he states that he is aware that he is in a mental hospital, it is always well to ask point blank why he thinks he has been brought there? Questions as to whether he recognises anybody here, or whether he has been here before, may now follow. The answers to many of the questions may appear simple and childish, but in the patient's manner of answering and behaviour whilst so doing, it may by now have been possible to notice some deviation from the normal, sufficient at any rate to put the medical man on the track of the particular mental disorder. If, however, by this time nothing abnormal has been found, examination of the special senses should be undertaken, with questions bearing directly on the sense actually being examined, e.g.: Are you deaf at all? Have you ever been deaf or worried by noises in the head? Have you fancies that you could hear persons talking to, or about you, when no one was present? The patient should be asked as to how he thinks such noises are produced, who produces them, and for what reason. Similarly with foul gases or obscene and terrifying visions.

If, however, nothing definite can be ascertained

up to this stage, the next point to investigate is the affective condition. Is he unduly hilarious and contented with his position, is the prevailing feeling one of misery and dejection, or is the condition one of utter indifference and lack of interest? The importance of this can hardly be over-estimated; from the patient's general outlook and attitude to the rest of the world it is frequently possible to obtain a guide as to the whole nature of the malady, and any marked deviation from the accepted normal should be gone into at length, particularly as to the patient's own explanation of it.

By this time a fairly accurate estimate will have been formed as to the general state of psychomotor activity present. Is the mental reaction to stimuli unduly retarded or, on the contrary, is the ideational train one of such activity that it is difficult to keep pace with it? Is the patient noisy, aggressive, or destructive? If so, endeavour to find the reason. For example, a man may destroy his bedding to show his strength, or because it is unfit for a person so exalted in degree as himself, or in order to fasten a piece of it round his throat. In all such actions it is of the first importance to discover the reason of their performance.

Next proceed to examine, if possible, the state of the patient's volition. Is he unable to attend to what is said to him? or to attend to the calls of nature? Is he actively suicidal or dangerous to others? Has he difficulty in making up his mind as to the simple details of ordinary life? Some patients would, if permitted, spend hours in perplexity as to which boot to put on first, and then be tortured by doubt during the rest of the day as to whether their action was right.

Finally, examine as thoroughly as possible the moral and sexual state; in many female cases this

may safely be left to the head nurse, but some patients will refuse to give any account of such matters to anyone but a medical officer, and he must employ his own judgment as to which method to adopt in individual cases. So far as possible it is wise for him to examine in a routine manner, taking the various faculties in the same order in every case, but following up each point indicating mental illness or derangement as it appears, and then completing the examination in the ordinary way.

On one point, however, stress must be laid—the notes on the clinical record should be made at the time of the examination and in the patient's presence. The entry thus made may be badly composed, and the grammar even defective, but such notes are, as a rule, more accurate and valuable than carefully edited statements transcribed at a later date from rough notes made at the time. The head and charge nurses should always be asked what signs of insanity, if any, the patient has exhibited to them ; they are usually skilled observers, and many patients who keep a close watch on themselves when the medical officer is in the ward, are less careful when they think that they are not likely to be observed by any doctor. In every case as far as possible, and as soon as possible, a complete and thorough history should be obtained from the relatives or friends. This history should embody facts, not only of the present illness, but preferably of the patient's whole life from childhood. Education, employment, illnesses, and amusements, should all be investigated, special attention being given to such points as alcohol and venereal disease, in regard to both of which relatives are apt to be unreliable either inadvertently or by design. The statement that " she is almost a teetotaler " frequently means only that the speaker has never seen the patient speechless or incapable,

QUESTIONS WITH REFERENCE TO PATIENT'S RELATIVES

If DEAD, state if possible the cause of death, and age at death.	State here if any have habitually given way to ALCOHOLIC INTEMPERANCE, and in the case of Patient's Father or Mother, state whether such habits commenced prior to Patient's birth or not.	State here if any have ever had a MENTAL BREAKDOWN; if so, at what age and where treated.	State here if any now or ever the subject of EPILEPSY, or if at all Paralysed.	State here if any now has or ever had CONSUMPTION.

BODILY DISEASE—

eadings as :—

akes of identity, &c.

of ideas, reasoning powers, memory of remote, recent, and current events,

Auditory, visual, gustatory, olfactory, tactile and organic hallucinations and sation, relationship to hallucinations, affective states, or bodily conditions, &c.

happiness, affective deficiency, morbid fear, &c.

as, rhyming, delirium, pressure and nature of activity, noise, restlessness,

uicidal, Homicidal, Erotic, &c.), catalepsy, automatism, negativism (*muscular ne, fæces and saliva*), stereotypy and mannerisms, obsession, doubt, employment,

affection, sense of right and wrong, truthfulness, criminality, erotism, al habits, alcoholic habits, &c.

and further inquiry may elicit the fact that the patient was a steady drinker. In seeking information as to venereal disease, leading questions should be avoided; in male cases the patient himself will, as a rule, return honest answers to questions, and it is unnecessary and unwise to direct the inquiry to such persons as the wife unless there is some special reason for so doing.

In regard to visitors to female patients, if the visitor be the husband, here again definite inquiry may be made, but if, on the other hand, the visitor be a female, one's inquiries should be limited to such indications as miscarriages, prolonged hospital treatment, falling hair, rashes, etc., in the ordinary way. The relatives should also be asked to what cause they ascribe the illness, and, finally, as accurate a history of the patient's family as possible should be obtained, especial attention being paid to insane, alcoholic, and criminal heredity. It is the custom in many hospitals now to send a form embodying most of the above-mentioned questions to the friends of a patient immediately after admission. The information gained by these is sometimes valuable, but a much more satisfactory result is obtained by means of a personal interview. Whether either or both of these methods be employed, the information should be summarised in the case sheet, in order that a complete record may be always available from the one source, as if the inquiry form and the results of the medical officers' interview with the friends be simply attached to the case sheet, it is always likely to be lost or mislaid.

Correspondence.—" The manager of every institution for lunatics, and every person having charge of a single patient, shall forward unopened all letters written by any patient and addressed to the Lord Chancellor or any Judge in Lunacy, or to a Secretary

of State, or to the Commissioners, or any Commissioner, or to the person who signed the order for the reception of the patient, or on whose petition such order was made, or to the Chancery Visitors or any Chancery Visitor or to any other visitors or visitor or to the Visiting Committee, or any member of the Visiting Committee of the Institution, in which any patient writing such letters may be, and may also at his discretion forward to its address any other letter if written by a private patient." [Sect. 41 (1).]

" Every manager of an institution for lunatics and every person having charge of a single patient who makes default in complying with the obligation imposed on him by this section shall for each offence be liable to a penalty not exceeding twenty pounds." [Sect. 41 (2).]

This section, whilst referring to the medical superintendent, is one to which the medical officer must give particular attention. Many patients, especially delusional cases, believe that their letters to Statutory Authorities are suppressed, and give them to the medical officer, as being the person in whom they have the most confidence. It is then his duty to pass them through the office in the ordinary way, as many hospitals keep a record of all such letters sent.

With reference to " the person who signed the order for the reception of the patient, or on whose petition such order was made," a patient may ask for the name of the justice or petitioner. There is nothing in the Act implying that the patient has a right to this information, and the best way of dealing with such requests is probably to ask the patient to write the letter and seal it, and say that you will then address it for him, and see that it is sent.

As regards correspondence not directed to Statutory Authorities, the medical officer is expected to

exercise a distinct censorship. Any letters which he considers unfit for transmission or unnecessary, should be marked and initialled by him and laid before the committee at the time of their next visit. Letters which are likely to cause distress to the relatives, obscene writings, etc., should not be sent, but it is often wise to forward letters exhibiting marked delusions, as they convey clear evidence of the patient's mental state, but they should be sent only when addressed to near relatives. Complaints with reference to detention, food, etc., are not in any way reasons for detaining letters, unless they are obvious fabrications, written simply with a view to eliciting sympathy, money, etc. Finally, from time to time patients give vent in their letters to false beliefs which they refuse to give in ordinary conversation. Such letters are valuable if affixed to the clinical record, and should have the date clearly marked.

A class of patient which not infrequently gives rise to a certain amount of trouble is the chronically deluded and persecuted lunatic, who, having developed an idea that letters are being suppressed, writes to the persons he imagines to be persecuting him, or to the Royal Family, or some newspaper, and conspires to get them posted outside. He usually does this by handing the letter to his visitors, or to some other patient who is regularly visited, by throwing the letter over the boundary wall whilst exercising, or by actually posting it whilst out on a shopping expedition. It is extraordinary how foolish some apparently sensible visitors can be on this point, and also what clever schemes some patients will evolve to elude the vigilance of the hospital staff. Once a patient is known to be in the habit of doing such a thing, it is well to give certain instructions to the head nurse, viz. that whenever the patient

is seen to be engaged in writing, even though a letter is handed in in the ordinary way, his or her clothes must be carefully searched as soon as bed-time arrives, and arrangements made for special observation to be kept on the patient during visiting hours. Shopping privileges should be restricted, and the patient informed of the reason. Any letter found by such measures will, of course, be dealt with in the ordinary manner, and if visitors are detected in the act of taking out letters surreptitiously, they should be warned that they are breaking the rules of the institution, and that persistence in such behaviour may entail the restriction of their visits.

Letters from Relatives *re* Patients.—The usual method of dealing with correspondence from the friends of the patient is for the letter, after being booked up in the office, and the patient's number and ward being noted on it in pencil, to be handed to the medical officer in charge of the patient. It is his duty to furnish the medical superintendent, as soon as possible, with a written report as to the patient's mental and physical state, in order that the inquiry may be answered on the day of receipt. It is obvious, therefore, that the medical officer must interview the patient before writing his report; otherwise, sooner or later, he will furnish a report which is not only misleading, but inaccurate. A patient who was perfectly well on the previous evening, may have a temperature of 100° and incipient pneumonia on the next morning. The report need only be a brief one, but should state whether any improvement, physical or mental, has been observed. From this up-to-date report and his own knowledge of the patient, a reply to the letter is quickly drafted, and the matter dealt with by the particular clerk concerned, this form of correspondence all passing through the medical superintendent's office.

Visitors.—The practice with regard to the interviewing of patients' friends varies in different hospitals. In some, all friends who are visiting for the first time since the patient's admission are seen by the same medical officer; in others, the medical officers interview visitors in turns.

The first visit is, however, the important one, and every effort should be made to extract as full and clear a history as possible, not only of the patient's illness, but of his previous life and his family history. It is only by careful work in this way that causative factors can be discovered, and also it may be pointed out that the falsity of some patients' beliefs can be actually proved. The chief thing that interests the friends, however, is the prognosis, and a wise rule is to refuse to offer one until at least a month has elapsed since the admission of the patient. When the case is a clear and definite one, the prognosis can usually be given frankly and openly, but in more obscure cases, where the diagnosis is at the moment in doubt, it is wise to be guarded, and to make certain of not erring on the side of optimism.

With regard to complaints by visitors, it is always best to investigate the matter then and there, and if they still express dissatisfaction, to invite them to make a full statement in writing to the medical superintendent, if there appears to be any reason for complaint. In the same way, there are always some people who insist that the patient is quite well, and should not be detained. If, after a full description of the patient's mental state, the visitor's attitude remains unchanged, the same advice should be given.

In the case of friends visiting in answer to a notice of illness or accident, it is necessary to make a point of seeing them and explaining fully the nature of the illness or accident; by so doing the natural anxiety of the friends is relieved.

PLEASE NOTE:—*Change of address or first visit must be marked on the top of the pass "new address" or "first visit," otherwise the address will not be recorded.*

VISITOR'S PASS.

Number in Register. .....

Allow Bearer to visit Patient (Name of Patient in full) .....

Name and Address of Visitor. .....

.....

.....

Relationship (if any) .....*Date*.....

This Pass must be filled in by the Visitor before arriving at the Asylum.

Notice of Change of Address should be immediately sent to the Clerk of the Asylum.

Patients may not be visited more often than once a week, unless an "Illness Notice" has been received by the friends, when they may visit at any time.

Infants in arms will NOT be admitted.

VISITING DAYS: From 2.30 p.m. to 4.30 p.m. on SUNDAYS, MONDAYS, and BANK HOLIDAYS.

Some visitors have a very undesirable effect upon their friends, and in any case where the medical officer is of opinion that the patient's mental state is reacted upon unfavourably, he should consult the medical superintendent with a view to the visiting being stopped for a time at any rate.

In the same way, it is inadvisable to allow the friends to visit a patient who is suffering from acute mania, unless there is reason for fearing a fatal termination on physical grounds or because of exhaustion.

Visitors frequently bring with them documents of some kind, to which they are desirous of obtaining the patient's signature; this should in no case be permitted without the direct consent of the medical superintendent. It may be pointed out to friends that such a document signed by a patient unknown to any member of the medical staff could probably not be legally maintained.

A few words as to the visiting of patients by solicitors and medical men not connected with the hospital may not be out of place. If no special rules as to these visitors are laid down, the medical officer should lay the matter before the medical superintendent before according permission. The usual custom is to make an appointment with the professional man, and, if no objection is obvious, to allow his access to the patient in the presence of one of the officers, but it should be clearly ascertained beforehand what the object of the visit is, e.g. whether it is desired to examine the patient. The reason for such precaution is clear when it is remembered that the relatives may object to such examination, or may themselves have instigated it with a view to possible legal proceedings against previous employers in whose service the patient may have received some injury. In such cases it is customary

to afford the same facilities for examination, and the same evidence as to the patient's condition to both parties likely to be concerned in any action that may be brought.

Usually, special hours for visiting are laid down on certain days of the week, except in the case of patients who are seriously ill, in which case visiting is permitted at all times, and this privilege is often extended to relatives who live at such a distance as will only permit of infrequent visits. Persons whose duties preclude them from visiting on the ordinary days are usually permitted to visit at such times as are convenient to their employment; and clergymen are, as a rule, allowed to visit at any reasonable time. In the case of Roman Catholic patients, it is needless to say that every facility should be placed in the way of the visiting priest to administer any rites he may consider necessary.

Illness Notices.—When a patient is taken ill with any bodily disease, it is the custom to inform the relatives, either by letter or wire; in any case the medical officer is called upon to dictate to the head nurse the particular wording which he desires should be used, and to sign the notice and counterfoil in the book kept in the infirmary wards for the purpose. The notice when detached from the book is sent, as a rule, to the clerk of the hospital, who posts the official notice to the relatives.

Arrangements vary in the different hospitals as to procedure when the clerk's office is closed, but the duty then devolves on the head nurse, if the case is urgent.

The question of when to send or not to send illness notices is often a very difficult one to settle; on the one hand, nobody wishes to put the relatives to unnecessary expense and anxiety, but it must always be remembered that in the event of any fatal issue

.....192

NOTICE OF ILLNESS.

The Medical Superintendent regrets having to report that .....

is .....

.....

.....*may be visited at any time on the production of this notice. Please inform other relatives (if any are known).*

To.....

.....

.....

---

occurring, the friends will be the first to complain that they were not informed, and, therefore, had no opportunity of seeing the patient; and there is a by no means small section of visitors who will hint that the reason for not sending for them was because the hospital authorities desired to conceal something from them. Each case, therefore, must be considered individually; any serious disorder, such as dysentery, influenza, pneumonia, etc., should always be notified, but slight rises of temperature, with no very marked physical signs, may well be observed for forty-eight hours or so by the medical officer, before deciding whether or not to let the friends know.

Severe casualties, such as fractures, should always be notified, and instructions given that the visitors

must interview the medical officer when they come, thus ensuring that they are in full possession of the facts concerning the accident. The same procedure as regards notification may also be adopted in patients admitted in a pregnant state. In the case of demented seniles, and other patients who have been ill and bed-ridden for a long time, it is frequently wise to send a notice with the following or some similar wording: " is becoming more feeble."

When the medical officer is confronted with some sudden and grave illness, such as cerebral hæmorrhage, etc., the question of sending a telegram arises, and it is wiser to send too many than too few ; it is most desirable that a death should not take place in a mental hospital without the relatives having been fully warned of the likelihood or possibility of a fatal termination, but this is, unfortunately, not always possible, many cases in which perhaps cardiac lesions and excitement are both present, suddenly collapsing. This statement also applies to epileptic patients and to general paralytics.

In cases of sudden death, as will be met with from time to time, a wire should be sent at once to the relatives, asking them to visit the hospital. The medical superintendent will in the meanwhile communicate with the coroner, who settles whether an inquest is necessary or not, and the relatives have an early opportunity of interviewing the coroner or his officer before the inquest is held if they so desire.

CHAPTER X

RECOVERIES

Discharge of Patients: (1) Pauper—(2) Criminal—(3) Private.

As soon as a patient has manifested such signs of recovery as to make it appear that constant supervision is no longer necessary, he or she should be removed from the admission hospital to the convalescent ward or villa, where greater liberty, freedom from the company of acute cases, and association with other hopeful convalescents, are all likely to be factors in completing the recovery.

In many hospitals the convalescent wards are run on a system of open doors, and especially on the male side a large number of patients are allowed on parole. It is usual to ask such patients to give their "word of honour" to their medical officer that they will make no effort to leave the hospital until discharged in the ordinary way, and to furnish them with a certificate stating that they are on parole, which certificate also enumerates the boundaries within which such parole may be exercised.

In a large hospital it will be found absolutely necessary to keep a list of recovering patients which must be kept up to date and revised weekly. Before recommending any patient to the medical superintendent for discharge, there are certain points which must be settled, the first being the method of discharge which it is proposed to recommend, the decision in this, of course, resting solely with the

medical superintendent, who will probably desire from the medical officer some amount of information regarding the home conditions, etc., which the latter should have elicited from the relatives. The most usual ways of discharging patients are: (*a*) After trial [Sec. 77 (2)]. (*b*) Undertaking [Sec. 79]. (*c*) In the case of private patients, discharge ordered by persons making last payment [Sec. 72].

Other methods less commonly used are as follows: (*d*) By order signed by three visitors [Sec. 77 (1)]. (*e*) By order signed by two members of the Board of Control, one medical and one legal, made within seven days of their visiting the patient [Private patients, Sec. 75].

(*f*) The visitors of an asylum may send notice in writing, signed by the clerk, of their intention to discharge a patient to the relieving officer of the union to which he is chargeable, and upon receipt, the relieving officer must remove the patient on discharge to the workhouse [Sec. 80].

(*a*) In both private and pauper cases the trial system is extensively used—the patient is allowed out to the care of friends for a varying period, usually four weeks. At the end of that period he returns to the hospital, is examined by the medical officer, and the reports of the relatives heard. Should these be satisfactory, and the medical superintendent be satisfied as to the patient's mental state, the latter is now discharged as recovered, and is a free agent. On the other hand, his trial may be extended, or he may be taken back into the asylum should a relapse have occurred, and this can be done at any time during the period of trial.

(*b*) Under Section 79, any two visitors may order the discharge of a patient on the signed undertaking of a responsible relative that the patient shall be cared for properly, and shall not again become chargeable to the rates. This latter provision is

frequently found to be ineffective, as there is no authority whose duty it is to see that it is properly carried out, and, as a matter of fact, a number of patients allowed out under this section ultimately have to be certified again, and a further expense is incurred by the Guardians.

(*c*) The Act provides that, in private cases only, the person on whose petition the reception order was made, or his legal representative [Sec. 72 (2)], can order the patient's discharge; unless the medical superintendent certifies the patient to be dangerous and unfit to be at large, with the grounds for such statement. The medical superintendent's certificates can be overruled by the written consent to the patient's discharge from (*a*) Two visitors, (*b*) "Commissioners visiting" the hospital [Sec. 74].

Alcoholic Cases.—It is frequently extremely difficult to know what to recommend in cases where alcohol is without doubt an important factor in the illness—a very large proportion of such cases improve very rapidly and make complete recovery, especially in first attacks, but as soon as they return to the world, the old temptations and habits recur, with the inevitable relapse and return to the hospital; possibly in such cases an extended trial is the best course, with the patient returning to the hospital for examination each month, so that, should a relapse occur, it is a comparatively simple matter to deal with the case.

Drug Cases.—The prognosis for complete and permanent recovery is just as unfavourable in these cases as in the preceding—they almost inevitably relapse, and the same method of dealing with them should be recommended, namely, that of extended trial.

General Paralysis.—In the event of a definite remission occurring in such a case, the relatives are

likely to become importunate and to adopt the view of a mistaken diagnosis, but the discharge of such patients is rarely, if ever, justifiable.

Epileptics.—Only in cases in which there has been no history and no sign of impulsive violence or automatism, where the Status Epilepticus is not likely to occur, and where the home conditions are known to be good, should the discharge of insane epileptics be considered.

Imbeciles.—The question of discharge here rests on many points, the most important of which probably is the amount of supervision which the relatives are able and willing to give. The danger of procreation is also of importance, especially in females, as the feeble-minded girl is only too well known as the source of a large proportion of illegitimate births. In men, the earning capacity and the lack of a history of violence or sexual malpractice, would also be factors to be considered.

Melancholics.—There is a particular form of melancholia occurring in late middle life, especially in women, in which, after an acute phase of varying length, the patient slowly improves to a certain extent, and then the mental state reaches a standstill which is definitely below the normal level. The question arises then as to whether the release to her own home will not complete the recovery which seems to have aborted. Frequently the cases do very well if allowed out on trial, but here the question of suicide is the most important one, and must be taken into very serious consideration if the husband or children become unduly pressing. The constant presence at home of an adult daughter or other female relative might here be allowed to weigh in the patient's favour.

Paranoiacs.—This type of case, and by paranoiac is meant the true systematised delusional case,

exhibiting grandeur and persecution, should never be discharged or allowed on trial ; they are always potentially dangerous, and give no warning of intended mischief.

Senile Dements.—Here the question of discharge rests largely on the form the mental illness takes. Faulty habits, noisiness, restlessness (particularly at night), the possible need for substitute feeding, and the ability of the relatives to afford the necessary care and attention must all be taken into account. It may be said in conclusion that no doubtful case should ever be recommended without as full and accurate a knowledge of the home conditions as can possibly be elicited from the patient and his or her friends.

No reference to the discharge of patients and the many questions that may arise in connection therewith would be complete without a description of the Mental After Care Association. This society, which is entirely supported by voluntary contributions, comes to the assistance of the committee and medical superintendent in cases where patients on recovery have either no friends to receive them, or whose friends are persons to whose custody it appears to be undesirable to transfer them.

Their work is especially valuable with regard to supervision of cases with an alcoholic history, cases in which for various reasons the home conditions are bad, and cases without friends. They have recently made arrangements to receive patients while the latter are on probation, to find them employment, and to report regularly as to progress. Their agents will also visit patients on trial living at their own homes and report as to conditions. It is not too much to say that this association is now indispensable so far at least as London is concerned.

It has earned the good will of the Board of Control

and of every medical superintendent in the country, and one can only hope that in the future the good work which it has performed for many years past may receive fuller recognition from the general public.

Private Patients.—A private patient must be discharged :

(1) On the receipt of an order signed by the petitioner or his representative as laid down in Sec. 72 (2), unless the medical superintendent certifies in writing that the patient is " dangerous and unfit to be at large." This certificate, however, may be overruled by a written consent to the discharge signed by :

(*a*) Two visitors.

(*b*) " The commissioners visiting."

(*c*) The visitors (of a licensed house)—or

(*d*) One commissioner (in the case of a single patient).

The certificate must contain the grounds on which it is made, and the word " dangerous " is commonly held to imply " to self or others," although the Act does not specifically say that this is the meaning intended. [Sec. 74.]

(2) By order of two members of the visiting committee, on the written recommendation of the medical superintendent. [Sec. 77 (2).]

(3) By order of three members of the visiting committee. [Sec. 77 (1).]

(4) By order of one legal and one medical member of the Board of Control made within seven days after they have visited the patient. [Sec. 75.]

(5) Seven days after notice of recovery has been sent to the petitioner, or to the person who made the last payment on behalf of the patient. [Sec. 83.]

Pauper Patients.—A pauper patient must be discharged :

(1) On an order signed by two members of the

visiting committee, on the advice in writing of the medical superintendent. [Sec. 77 (2).]

(2) On an order signed by two members of the visiting committee on the "undertaking" of a relative or friend of the patient. [Sec. 79.]

(3) On an order signed by three members of the visiting committee. [Sec. 77 (1).]

(4) On an order signed by the authority liable for the maintenance of a patient when confined in a hospital or licensed house [Sec. 73 and 74], unless the medical superintendent signs the certificate as described previously, in which case his certificate may be overruled by:

(*a*) "Commissioners visiting."

(*b*) The visitors of the House, or

(*c*) In the case of a single patient, one of the commissioners.

(5) On an order signed by one legal and one medical commissioner and made within seven days from the date of their visit. [Sec. 75.]

(6) On the expiration of seven days from the date upon which notice of recovery was sent to the Guardians or other authority liable for the patient's maintenance. [Sec. 83 (3).]

Section 78 provides that when a patient—pauper or private—is detained in a house licensed by Justices, he must be discharged on an order signed by two visitors, provided that:

(1) One of them is a medical man; and

(2) That they have visited the patient twice at intervals of not less than seven days.

This section also empowers the two visitors to examine the medical officer "if he tenders himself for examination," and specifically excludes a "lunatic so found by inquisition."

On discharge of a pauper *who has not recovered* to workhouse [Sec. 25], the medical superintendent

must furnish a certificate which must accompany the patient to the workhouse, that the patient has not recovered, and is a proper person to be kept in a workhouse as a lunatic, and this certificate is the authority for his continued detention.

Note : —A patient is not discharged under this section unless the medical officer of the workhouse has certified in writing that there is proper accommodation in the workhouse for the lunatic.

Criminal Lunatics.—The position here is a somewhat different one from that in the preceding cases.

If the patient has been sentenced to a definite term of imprisonment previous to his transfer to the mental hospital, and, in the opinion of the medical superintendent, before the expiration of that sentence, has recovered, the latter can discharge him, *only* on receipt of a warrant from a Secretary of State, directing him to do so. If, however, the sentence expires, and the medical superintendent is of opinion that the criminal is still insane and a fit person to be detained, it is his duty to notify a Justice of the Peace "having jurisdiction where such asylum is situate" that the patient's sentence is about to expire. The J.P. has authority then to make an order for the patient's continued detention ; this order, which may be made at any time within a month before the conclusion of the sentence, comes into operation automatically when the sentence expires, and the patient then passes from the criminal to the pauper class. [Sec. 7, Criminal Lunatics Act, 1884.]

It shall have the same effect as an order of a Justice, and a medical certificate made in pursuance of Sec. 68, Lunatic Asylums Act, 1853. [Sec. 8 (2), Criminal Lunatics Act, 1884.] An order so made has the same effect as a Summary Reception Order.

CHAPTER XI

CONTAGIOUS DISEASES, ETC.

CONTAGIOUS DISEASES: Tuberculosis—Dysentery—Enteric Fever—Scabies—Parotitis.

OTHER DISEASES FREQUENTLY AFFECTING THE INSANE: Insane Ear—Herpes Zoster—Circulatory Disorders—Chilblains—Gangrene.

CONTAGIOUS DISEASES

CERTAIN of the more prevalent contagious diseases amongst the insane have been dealt with in another chapter, but it is necessary to point out the lines upon which sporadic cases of the exanthemata, etc., are dealt with. As may be imagined, the occurrence of a case of any acute specific fever in a large institution containing many feeble and debilitated people is an occasion for grave alarm, and prompt and drastic isolation must be undertaken at once. If no isolation villa is provided in the hospital, the instructions of the medical superintendent must be sought as to the patient's disposal, but meanwhile every possible precaution should be taken in the ward in which the case originated. Clothing, bedding, etc., must not be sent to the laundry with the ward washing in the ordinary way, but treated as foul laundry and sent at once to the disinfector. Orders must be given for the disinfection of the room after the patient's removal, and attention should be given to all utensils, etc., which he or she has used. The medical superintendent will decide whether or not the "contacts" must be isolated, but the medical officer must in any case keep them under strict supervision until all danger is past. The chief point upon which stress

must be laid is that all suspicious cases must be regarded as contagious if the diagnosis is not clear; full advantage should be taken of any assistance that the pathologist may be able to give, e.g. examination of swabs from suspicious throats, and the conducting of Widal reactions in the case of doubtful enterics.

When one considers the large staff, and constant visiting by relatives, it is remarkable how free from epidemics the ordinary mental hospital keeps, and no precaution should be neglected which tends to maintain this desirable condition. Occasionally a case of scarlet fever or measles arises, and, as a rule, when this happens, it is not possible to trace the infection, but if it should come to notice that a patient's friends have contagious illness in the home, their visiting should be stopped for the time being.

If a case of contagious disease occurs in the home of a *non-resident* member of the staff, arrangements are usually made for his or her accommodation in the hospital until a certificate of freedom from infection is supplied by his family doctor.

Tuberculosis.—This disease, which at present is exercising the minds of the entire medical world, has for many years past been one of the most important causes of death in asylums. In the more modern hospitals a special villa is set apart for the treatment of tubercular patients, or if that cannot be provided, at least a special ward is reserved in which no patient, not the subject of active phthisis, is treated. The chief difficulty of the medical officer, however, is not treatment, but early diagnosis. In many patients the very conditions which predispose to the infection of tuberculosis, such as lack of energy and movement, shallow respiration, etc., give rise to much increased difficulty in examination, and the doctor who prides himself on his accurate knowledge of physical signs may find himself absolutely at

No.....

Date of Admission .....

CAUTION AS TO TUBERCULOSIS **T**

Name.....*Mental State* .....

Date of Recovery, Discharge or Death.....

	Ward.	No. of Bed in Dormitory.	Signature of Medical Officer.
Suffering from Tuberculosis on Admission			
Developed Signs of Tuberculosis ..			

To the Charge {Attendant / Nurse} Ward .....

who will be held responsible for the due carrying out of the following Orders.

1. That this caution form accompanies the patient if moved to another Ward or Hospital.
2. That it hangs on a special clip against the wall in the Store Room.
3. That every Day and Night {Attendant / Nurse} on duty in the Ward reads it.
4. That whenever fresh {Attendants / Nurses} come on duty in the Ward, even if only temporarily, they be shown it.
5. That it be laid out for inspection once a week at a medical visit, and that it remains in force until withdrawn by the Medical Superintendent.

I have read the caution relating to this Patient and understand that she is suffering from Tuberculosis and, therefore, the importance of carrying out the directions given by the Medical Officer with regard to this case.

Signature of Charge or Acting

Charge {*Attendant* / *Nurse*} .....*Ward*.....*Date*.....

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sea with the insane patient. There is one great safeguard in the disease, and that is the regular weighing of patients, but only if this is accurately done. A scarcely noticeable cough, plus a loss of weight, even if slight, should be an indication for putting the patient to bed in an infirmary ward, and keeping an accurate record of the temperature, whilst the chest is carefully examined from day to day. If sputum can be obtained, several smears should be examined on different dates, but it must be remembered that in the case of the insane, particularly the young stuporose primary dement, it is extremely rare that sputum can be obtained until late in the disease. Von Pirquet's and Calmette's reactions both prove useful at times, but may be misleading in their results. A persistent evening rise of temperature, even if very slight, must be regarded as extremely suspicious, if nothing more, and the importance to be attached to a tubercular family history is probably greater in the insane than in the normal population. It is possible that in the future, when every asylum possesses its own X-Ray outfit, more successful results in early diagnosis may be obtained, but at present there is no question that every medical officer meets many cases in the course of his experience in which he is in doubt until the disease is well marked. Once the diagnosis is certain, the treatment must be carried out as nearly as possible on the ordinary sanatorium lines, with such modifications as may be absolutely necessary from the patient's mental state.

The mental states in which pulmonary tuberculosis is most frequently met with, are dementia præcox (especially in the stuporose type), melancholia, and imbecility with degenerate physique. This is largely what one would expect from the effect of the mental state on bodily movement and metabolism. The young patient in an institution who stands about,

and exhibits shallow respiration and depressed circulation, offers an ideal site for the development of the tubercle bacillus, especially in view of the fact that cough, even if present, is ineffective. A certain amount of senile tubercle is also seen, but usually of a very chronic type, and it is not, as a rule, these cases which give rise to the anxiety, or to the difficulty in diagnosis.

To sum up, an accurate knowledge of his patients by the medical officer, and regular monthly weighing, are the two factors upon which most reliance must be placed in early diagnosis.

Whilst pulmonary tuberculosis is a common and fatal disease in the insane, other forms, such as glandular, spinal, and joint infection are distinctly rare, but, if seen, must be dealt with along the customary surgical lines. The results here are usually favourable unless the case is one in which it is impossible to keep the wound and dressings clean; in such a case, special nursing arrangements should be made.

In many of the cases which develop phthisis in a mental hospital, sooner or later infection of the intestine by the tubercle bacillus takes place. Especially, as might be expected, is this likely to occur in demented and resistive people who do not expectorate, but habitually swallow such sputum as may reach the pharynx.

Dysentery.— This disease, otherwise known as ulcerative colitis, is unfortunately still one of the most common diseases in mental hospitals. Year after year, the Board of Control show in their reports a large number of cases spread all over England, and in a considerable proportion terminating fatally. It is now believed by many men to be identical with the tropical dysentery due to infection with Shiga's bacillus. If, however, this

is so, it is very difficult to understand why the disease should be so rare in this country outside mental hospitals, and, secondly, why members of the nursing staff are so rarely attacked. A very large amount of work has been done on the subject, particularly by Sir Frederick Mott, but as yet no certain method of stamping out the disease in a mental hospital where it has once made its appearance, has been discovered. In view of its rarity apart from mental hospitals, a few notes as to symptomatology may not be out of place. The classical symptoms are abdominal pain, fever, and loose evacuations containing blood and mucus, with a most offensive odour. Any cases presenting this picture give rise to no difficulty in diagnosis, and should be forthwith isolated in a special villa, ward, or block, and whilst many may think it unnecessary, it is the custom in many hospitals at once to isolate any patient who has loose motions with a rise of temperature. The diarrhœa is, as a rule, not so persistent nor so profuse as in the real tropical disease, but is extremely variable in amount and duration. Some cases start with a high temperature, profuse diarrhœa, and, in spite of treatment, progress rapidly to collapse and death. Others start more gradually, never become very acute, and slowly subside; whilst a third type of case runs a very prolonged course, apparently clearing up and then relapsing after about two or three days. There is no doubt in the mind of anyone who has seen much of the complaint that this liability to relapse is common to every type of dysenteric attack, and is the chief cause of the inability to exterminate the disease which has been previously noted. Once a patient has had dysentery, a relapse is not only possible, but likely, and many medical superintendents recognise this fact by issuing a special card,

CAUTION AS TO DYSENTERY

D

.....*Date of Admission.* *No*.....

Name..... *Mental State*.....

Attack.	Ward at time of Onset.	No. of Bed in Dormitory.	Date of Isolation.	Date of Recovery Removal from Isolation Hospital.	Signature of Medical Officer.
1st					
2nd					
3rd					
4th					
5th					
6th					

To the Charge {Attendant / Nurse} **Ward** .....

who will be held responsible for the due carrying out of the following Orders.

1. That this caution form accompanies the patient if moved to another Ward or Hospital.
2. That it hangs on a special clip against the wall in the Store Room.
3. That every Day and Night {Attendant / Nurse} on duty in the Ward reads it.
4. That whenever fresh {Attendants / Nurses} come on duty in the Ward, even if only temporarily, they be shown it.
5. That it be laid out for inspection once a week at a medical visit, and that it remains in force until withdrawn by the Medical Superintendent.

I have read the caution relating to this Patient who I understand has suffered from an attack of dysentery, and therefore must be carefully watched ; and any symptoms of illness, especially weakness, blood, slime or mucus in the stools (even with formed motions), loose motions extending over more than 24 hours, even if unaccompanied by blood or slime, must be at once reported to the Medical Officer, in order that precautions may be taken against the infection of other patients.

Signature of Charge or Acting

Charge {*Attendant* / *Nurse*} .....*Ward*.....*Date*.....

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Care must be taken on the part of **all attendants** (for their own as well as others' protection) to wash their hands after changing or handling clothes of patients, especially those suffering with diarrhœa or dysentery ; to convey in accordance with instructions foul linen to proper receptacles ; not to use feeding utensils of any kind for other patients, which have been used by patients suffering with diarrhœa or dysentery, unless they have been thoroughly cleansed : in all cases to cleanse and disinfect the nozzle of enema syringes after use, and to carry out all other instructions of the Medical Officers for the prevention of the spread of the disease.

which is kept with the clinical record during the rest of the patient's sojourn in the mental hospital, and is a warning to any fresh medical officer or nurse with whom he or she may come in contact. There is, unfortunately, good reason to believe that recovered dysentery patients may for years act as "carriers," and this fact increases the importance of segregating such cases. So far as possible, patients who have been attacked and have recovered should be kept in special wards. This at first sounds obvious and easy, but in a mental hospital, with its constantly changing population, it is really most difficult. Even granted that these patients are all carefully segregated in one ward, what is the position? If one of them develops pneumonia, is he or she not to be moved to an infirmary? If one of them is a good worker, is he or she to be debarred from attending chapel or any associated entertainment? There is no doubt that it could be done if sufficient wards and staff were available, but at the present time such a perfected method must be possible in very few of the large hospitals. At the same time every effort must be made to teach the nursing staff the enormous importance of hand-washing—not only after handling patients, but also bed linen, clothing, etc., and before meals. If for any reason dysentery has to be treated in a ward with cases of other disease, the dysentery case should, if possible, be in a single room, and every utensil which he is allowed to use should be marked distinctively. These utensils should be washed up separately, and kept apart from the general stock of the ward. As this disease is most contagious to other insane patients, every possible precaution to avoid infection is essential.

The treatment of dysentery, in its results, varies with the length of time during which the disease was

active before treatment was commenced. An enormous variety of treatments have from time to time been recommended, but in the author's experience nothing for efficacy approaches the Saline Treatment pushed vigorously; a dose of 2 drachms Mag. Sulph. (in saturated solution) is given every two hours until a liquid stool is passed which contains no blood or mucus, and then the same dose is given every four hours for a further period of twelve hours. If no further signs of blood or mucus are seen, a mixture of Bismuth and Opium is substituted. The diet should consist of milk and arrowroot. If the milk diet induces vomiting, as sometimes occurs, it should be mixed with rice water (one fourth by volume) and given in smaller quantities. There is no doubt that warmth is most important in these cases, and for the relief of pain a flannel binder or a hot fomentation is usually all that is necessary.

Collapse and heart failure are undoubtedly best dealt with by means of alcohol in small doses added to the food or medicine, but this complication is much less commonly seen if the temperature of the ward is not allowed to sink below 60°. Many other forms of treatment have been, and are being used, such as Ipecacuanha, intestinal antiseptics, such as Beta Naphthol, Salol, etc., intestinal lavage and Quinine, to give only a few examples, but in an experience of this disease, which has unfortunately been extensive, I have found nothing which gives such a large percentage of good results as the Saline Treatment. After the stools have become formed, and the temperature has remained normal for three days, it is safe to allow a small quantity of rice pudding, also bread and butter, and then gradually progress through fish diet to the ordinary meals. Some cases suffer severely from constipation after an attack of dysentery, and for these the first drug which should

be tried is liquid paraffin. It is expensive, but often can be discontinued after quite a brief course of treatment, and is, as a rule, efficacious in dealing with the condition. Perforation, leading to general peritonitis and death, is sometimes seen in a fulminating attack, and is almost invariably fatal. When perforations occur, they are frequently multiple, and the patient's state is so grave that operative interference is out of the question, but if this complication be diagnosed in a fairly robust patient, surgical measures should be undertaken. Attention must be paid during the illness to the state of the mouth, which rapidly becomes dry and foul ; frequent washing with warm water, to which a drop or so of Sp. Salol Co. has been added, gives much relief to the patient, and it has been suggested that there is some connection between pyorrhœa and dysentery, although no definite proof has been adduced.

It is rare to see any adhesion formed in the case of an old dysenteric, nor are any signs of such adhesion to be found in cases dying during an acute attack. Sequelæ of any kind, as distinct from relapses, are very uncommon.

The relatives and visitors to the patient should be made fully cognisant of the contagious nature of the malady, and warned against bringing children, or kissing the patient, etc.

It is to be hoped that some form of serum treatment may be ultimately discovered which will enable us to cope with this disease at present the despair of the medical staffs of mental hospitals.

Enteric Fever.—This disease, from which most of the English mental hospitals had been free for many years, again made its appearance in many of them during the war, and is exceedingly difficult to stamp out. The most important point, not only in the interest of the patient, but also of the institution, is

its early recognition, and this is frequently by no means easy, as so many of the cases are atypical, not only in the onset, but in their course. Constant supervision by a medical man who has an accurate knowledge of his cases, with immediate examination of any patient who looks ill, is the best guard that we have at present. Any patient presenting an unexplained rise of temperature for more than twenty-four hours, should be regarded as suspicious. No reliance can be placed upon the state of the bowels, as just as many patients are obstinately constipated as the reverse. A considerable proportion of patients start their illness with a sudden sharp attack of bronchitis. Headache is practically universal, but vomiting uncommon, and epistaxis rare. The most valuable indication, apart from the temperature and increasing listlessness, is the condition of the tongue. Nearly every case shows the typical enteric tongue, but unless the strictest supervision is maintained, it is undoubtedly possible for a stuporose primary dement to be ill for some days without being noticed, and in these cases reluctance to take food, replacing the former ravenous appetite, should always arouse suspicion.

The Widal reaction has, in the writer's experience, not proved at all reliable, several cases having been seen with a markedly positive Widal who proved to be cases of early tubercle ; on the other hand, quite a number of typical cases of enteric maintained a negative reaction throughout the course of their illness, specimens being tested on as many as three different occasions ; too much weight should not, therefore, be placed upon the test.

The virulence of the disease has varied markedly during the past few years, some attacks having been extremely mild and others, perhaps from the same ward, very severe. Apart from the necessity of

isolation of the active cases, the point will arise as to the disposal of recoveries ; these should, as far as possible, be confined to one ward, and every endeavour made to discover "carriers." If found, these patients should be kept *permanently* in the ward set apart for the treatment of acute cases of enteric. No patient who has had enteric should be allowed at any time to work in a kitchen or laundry, nor in such employment as vegetable cleansing, etc. This may sound unduly cautious, but the fault, if any, is on the right side. If the infection can be traced to any one ward without the original focus being actually detected, the medical superintendent should be consulted as to the advisability of inoculating the uninfected patients in the ward, and the opportunity of availing themselves of this measure of protection should most certainly be extended to the staff who are engaged in nursing these patients, and also to laundry maids and patients who are handling the foul linen ; in this connection the Board of Control have laid down the following recommendations as to the ideal method of disposal of clothing, etc. :—

(*a*) That all foul clothing and bed linen should be regarded as potentially infectious.

(*b*) That all foul articles should be placed immediately in a covered metal receptacle and be kept damp.

(*c*) That this receptacle should be kept as near as possible to the ward it serves, preferably in the open air, and should be of such a size that it can be carried by two persons to the laundry.

(*d*) That this receptacle should be carried to the laundry and emptied into a tank of cold water, which should, if possible, be outside the laundry building. In this tank the clothing should be boiled for at least twenty

minutes after stirring to remove the solid matter, and not taken into the laundry until thus disinfected.

(*e*) That this receptacle should then be rinsed out and disinfected by means of a steam jet before being returned to the ward.

N.B.—This method necessarily involves the discontinuance of the practice of counting articles into the laundry, but the advantages gained far outweigh the possible loss of stock that may result therefrom. The disinfecting process may also lead to the damage of many blankets. To avoid this it is suggested that between the mackintosh and the sheet should be placed stout sheeting or other warm material instead of a blanket.

As in the case of tuberculosis or dysentery, a card showing that he or she has suffered from enteric, should be issued for each patient on the day that the diagnosis is confirmed, and this card should accompany the patient in all future movements.

Scabies.—From time to time an outbreak of this disease may occur in a mental hospital, and whilst not in itself dangerous, it is most contagious, and must be stamped out quickly. Fortunately, this is, as a rule, easy if radical measures are taken. The patient must be isolated, every article of clothing and bedding which has been used disinfected, and treatment commenced. The old-fashioned sulphur baths, followed by the careful and thorough application by a nurse of an ointment, consisting of equal parts of Unguentum Sulphuris and Unguentum Acidi Salicylici, will usually clear up any case in three days, but the application of the ointment must be done personally by a nurse, who understands that each minute lesion must be treated individually, and that it is not sufficient to

smear the ointment broadcast. It is also important, when a case arises in a ward, that a careful inspection be made not only of the other patients, but also of the staff in the ward, as the contagion under modern methods is most likely to have been imported.

On the male side, cases of slight scabies frequently respond rapidly to the army method of treatment; the man is ordered a hot bath, and all burrows and skin lesions well scrubbed with a nail-brush and soap. He is then given an ordinary sulphur bath, in which he is allowed to remain for some considerable period. The treatment is carried out for three days; no ointment is used, and with a reliable staff the results are excellent. For some reason, possibly owing to the scrubbing not being so briskly done, or because the skin of women patients is too tender for it to be efficiently carried out, the results of this form of treatment are not nearly so good on the female side, and a course of ointment inunction is practically always needed.

Parotitis.—From some cause, which at present has not been elucidated, cases of this disease are by no means uncommon among the insane. The suggestion that it is due to the extension of sepsis from the mouth along Stenson's duct hardly suffices in these cases; firstly, it is usually not seen in the worst cases of pyorrhœa, etc., and, secondly, because it does not, as a rule, proceed to suppuration. It is usually unilateral, not particularly painful, and gives rise to no marked constitutional symptoms, but treatment should be active from the moment that it is observed. The patient should be kept in bed on liquid diet, the mouth rendered as clean as possible with tooth-brush and Salol mouth-wash, and Belladonna fomentations applied to the affected gland. Under this treatment most cases resolve fairly quickly, but if suppuration supervenes, probably the

best treatment is to puncture the gland with a tenotomy knife at a point where fluctuation is detected and apply Bier's suction apparatus. The more free opening by Hilton's method may be called for if the above-mentioned treatment fails, but in any case it should be remembered that any incision in this neighbourhood should be horizontal in direction to avoid all chance of injury to the facial nerve.

In any case of parotitis, the possibility of the case being one of epidemic parotitis must be borne in mind, although this is both uncommon and unlikely in mental hospitals.

Insane Ear (Hæmatoma Auris).—This condition, which has been recognised now for many years, is seen from time to time. The cases principally affected are general paralytics, epileptics, and chronic maniacs, but it also occurs in other varieties of mental disorder. The affected ear swells up, loses its shape, and becomes a tense bluish tumour. If attended to and protected from injury, this gradually subsides, leaving a hard, shrivelled, and misshapen appendage, often having but little resemblance to an ear at all. It is stated to be due to a degeneration in the cartilage of the ear, and in such cases a very small and insignificant trauma appears to be sufficient to initiate the condition. Formerly, it was believed that it arose without injury, but this is not now generally accepted.

No form of treatment appears to be of any use in minimising the deformity, although it is agreed that incision and clearing out the clot is unwise. Probably the old-fashioned treatment of painting over with blistering fluid and protecting it with cotton wool is as satisfactory as anything in promoting resolution. For years hæmatoma auris has been regarded as a bad prognostic sign, but this belief is most likely due to the fact that the majority of examples occur in

chronic and irrecoverable cases, who have already been under certificate for many years.

Herpes Zoster.—This disease is frequent in the insane, but why this should be so has never been explained. It occurs sporadically in wards without obvious reason, and does not seem to favour any particular nerve. Possibly the intercostal variety is the most common, but cases are frequently seen affecting the scapular, supraorbital, gluteal, and femoral regions. Little treatment is, as a rule, necessary, but the case should be kept in bed if running a temperature, and the affected area painted with collodion, which seems to give as much relief as anything, and also to minimise the scarring, which is at times so obvious after the vesicles have dried up. At times a case is seen with considerable constitutional disturbance, but this usually subsides with the full development of the rash. Cases occurring on the face should be an indication to examine teeth, eyes, and ears, although in many cases no exciting cause can be found.

Circulatory Disorders.—*Chilblains* are a common and very intractable ailment, affecting largely the younger patients, and especially the semi-stuporose primary dement, who will, if permitted, stand about in a fixed position with his hands hanging down, blue and cold. In addition to the feeble circulation, another factor which predisposes to this condition is the difficulty in ensuring that such patient's hands are properly dried after washing. Woollen gloves are of some value as a prophylactic, but when once the condition has developed, the treatment is frequently a tedious business. Rest in bed, with the affected parts dressed with an ointment consisting of equal parts of lanoline, vaseline, and almond oil, and then wrapped in cotton wool, produces resolution which is assisted by a course of treatment internally

with calcium chloride or lactate. Some observers have obtained good results from thyroid, but that has not been my experience.

Gangrene of varying degrees of severity is by no means rare in the senile case, with marked cardio-vascular degeneration. Palliative treatment is, as a rule, all that can be attempted, as in the event of surgical interference, the nutrition of the stump is almost certain to be defective and lead to further extension of the trouble. In the event of a definite line of demarcation forming, it may be found possible to assist the process and provide a useful stump, but the outlook in these cases, as a rule, is distinctly unfavourable.

A further point that may be noticed in the particular class of case mentioned above is the extensive ecchymosis that frequently results from an insignificant trauma. An attack of bronchitis may produce two blood-red conjunctivæ, or the mere pressure of the nurse's hand on the arm whilst assisting the patient to the table, a vivid bruise reaching from shoulder to elbow. This condition, whilst not peculiar to the insane, is of importance to the medical officer from the fact that the relatives may not unnaturally believe that undue violence has been used.

CHAPTER XII

RECEPTION OF PATIENTS

LEGAL CONTROL OF THE INSANE: Lord Chancellor—Masters in Lunacy—Board of Control—Public Asylums—Licensed Hospitals—Licensed Houses—Single Patients—The Lunacy Acts of 1890 and 1891—The Mental Deficiency Act of 1913—Other Acts.

PAUPER PATIENTS: Summary Reception Order—Transfer of Pauper Patients.

PRIVATE PATIENTS: Judicial Order on Petition—Urgency Order—Transfer of Private Patients.

SERVICE PATIENTS.

CRIMINAL LUNATICS.

LEGAL CONTROL OF THE INSANE

In England the supreme authority in all matters affecting the insane is the Lord Chancellor. He is assisted by three visitors, one being a barrister and the other two medical men, who visit twice annually all patients who have, or at any time have had, property which was administered by the Lord Chancellor, and who have been found insane upon inquisition by the Masters in Lunacy.

The Masters in Lunacy investigate cases of alleged insanity where property is involved, and are empowered to appoint a committee of the person or of the estate. The Masters in Lunacy are of necessity both barristers.

The Commissioners of the Board of Control (formerly the Commissioners in Lunacy) are a standing body, who are, in fact, the practical guardians of all insane or mentally defective persons in England. They visit all institutions or private houses where certified lunatics or mental defectives are detained,

and are authorised by the Lord Chancellor to make rules, to issue licences to private asylums, and to order prosecution in the event of non-observance of their regulations. It is to this body that any person who is engaged in the care or treatment of the insane is definitely responsible except in the case of lunatics so found upon inquisition. In county mental hospitals the superintendent is also responsible to a committee of management composed of members of the particular county council with which he is serving.*

In registered hospitals the superintendent is responsible to a committee of visitors. These institions are also regularly visited by the Board.

In licensed houses there is no committee, but the Law insists on one of the licensees being resident. The licence from the Board of Control must be renewed annually, so far as the Metropolitan area is concerned, and in other areas by the Justices.

The Act permits one insane person to be detained in a private house for gain, provided that the case is certified and reported to the Board. They can also grant special permits for two patients to be received into one house, but for any number in excess of this a licence is necessary.

The Guardians of the parish to which any pauper patient is chargeable are entitled to visit their patients if they so desire [Lunacy Act, 1890, Sec. 201 (1)], or can appoint a medical practitioner to do so. This visit is usually paid by the Guardians themselves once a year.

The *statutes* governing the certification and detention of private and pauper patients who are certified to be insane in England, are the Lunacy Act of 1890 and the Lunacy Act of 1891 (an Act to amend the Lunacy Act of 1890).

The Act governing the care and control of the

* *Vide* Special paragraph.

Feeble Minded and Mental Defectives is the Mental Deficiency Bill, 1913, the full benefit from which has not yet been obtained owing to the fact that many authorities have not so far been able to provide the accommodation necessary for this type of case.

Soldiers are dealt with under a particular section of the Army Act [Sec. 91]. This section of the Act as amended by the Army (Annual) Acts 1891, 1894, 1899 and 1909, provides that an order of the Army Council or an Officer shall be of the same effect as a Summary Reception Order, within the meaning of the Lunacy Act, 1890; and the like proceedings shall be taken thereon as on an order under that Act.

An insane soldier or sailor, when once he has been classified as a "Service" case, is legally in the same position as any other "Private" case, with certain minor differences, e.g. that the person making the payments for his maintenance is the Minister of Pensions (*v.* page 175).

Criminal lunatics are dealt with under a special Bill commonly referred to as the Criminal Lunatics Act, 1884.

Reception of Pauper Patients

Summary Reception Order [Sec. 13 et seq.].—Order must be signed, dated, and addressed to the medical superintendent of the particular asylum, all blanks filled up and unnecessary words deleted. Order must be accompanied by statement of particulars and a medical certificate.* Order must be signed by a J.P. having jurisdiction [Sec. 9], or by the Chairman of a Board of Guardians who is empowered by the Lord Chancellor to do so, and who should then state that he is so empowered.

* Two certificates are required if the person is not a pauper, and not wandering at large, and is not under proper care and control, or is cruelly treated. If the Justice has not seen the lunatic, the requirements of Sec. 8 must be complied with.

Order must be dated not more than seven days before admission.

Exceptions.—(1) If execution suspended by J.P. (who must be the signatory), in which case interval may extend to fourteen days. [Sec. 19 (1).]

(2) If execution is suspended by medical certificate on account of patient's unfitness to travel. In this case order remains valid for an indefinite period until removed by another and separate certificate that the patient "is now fit for removal," when the patient must be removed to the hospital within three days. [Sec. 19 (2).]

(3) A J.P. can send a patient to a workhouse under a "detention" order after signing the reception order, in which case the latter holds good for fourteen days from the date of the signature, but the "detention" order must accompany that for the reception of the patient. [Sec. 21 (2).]

A pauper patient may not be refused admission if the documents *appear* to be in order unless:

(1) The Mental Hospital is full. [Sec. 27 (2).]

(2) [Sec. 75 (5)] (*a*): The medical superintendent may be empowered under regulations to exclude a patient who is suffering from contagious disease, and whose admission will entail risk to present inmates.

(*b*) Or a patient coming from any place where such disease is prevalent.

N.B.—*A Commissioner of the Board of Control* may order the superintendent of an asylum to admit a pauper patient, but must obtain one medical certificate before making such order. [Sec. 23 (2).]

Reception on Transfer from Another Mental Hospital. (Pauper Patient.)—[Secs. 58 to 71.] accompanied by:

I. An order for removal (see below).

II. Certified copy of original reception order, statement, and certificate. [Sec. 70 (3).]

Order of removal may be signed by:

(*a*) A Commissioner. In this case the patient must be admitted without reference to the district from which he comes. [Sec. 59 (1).]

(*b*) Two Members of the Visiting Committee. [Sec. 65.] Patient must be admitted on such order if:

1. He had previously by order of the Committee been removed from the asylum to the custody of his friends.

2. If the patient comes from another asylum of the same county or borough or any asylum with which the Committee have a contract.

3. If the patient comes from any asylum and has been adjudged chargeable to some parish in the area served by the receiving asylum.

4. If the patient comes from a workhouse in which he has been detained under Sec. 26, Lunacy Act, 1890.

(*c*) Two visitors of the asylum *from* which patient is brought after formal adjudication of chargeability. (Consent of a Commissioner to removal is required if chargeability has been "accepted" without a formal order of adjudication.) [Sec. 64.]

Reception of Private Patients

A. **On Order of Judicial Authority on Petition.**—The order becomes invalid under the following conditions:

1. If the asylum is wrongly named, or the name of another asylum used.

2. If the date of the order be more than seven clear days before the day of admission. [Sec. 36 (3).]

3. If the order be not properly signed. The order cannot be legally signed by a relative of the petitioner, or of the husband or wife of the patient. [Sec. 4 (1).]

4. If the patient be not fully and properly designated.

Other minor defects do not invalidate the order,

and may, with the consent of the Board of Control, be amended within fourteen days of the patient's reception. [Sec. 34.]

The certificate becomes invalid:

1. Unless it is clearly stated that the certifying medical man is on the register and in the actual practice of his profession. [Sec. 341.]

2. Unless the certifier definitely states "a fact indicating insanity" observed by himself at the time of examination. [Sec. 28 (2).]

3. If the date of the examination is more than seven clear days before the date of the certificate. [Sec. 29 (1).]

4. Unless it is stated that the examination was made "separately from any other practitioner." [Sec. 29 (2).]

5. If either certificate be signed by—[Secs. 30 & 32].

(1) The petitioner.

(2) Any relative, partner, or assistant of the petitioner.

(3) The superintendent of the hospital designated.

(4) Any person interested in payments on the patient's account.

(5) Any near relative, partner, or assistant of persons referred to in (3) and (4).

(6) Any near relative, partner, or assistant of the other certifying medical man.

(7) Any visitor of licensed houses appointed by the justices of the county or borough (except as provided for in Sec. 33, Lunacy Act, 1890).

Note: One of the medical certificates should, whenever practicable, be signed by the usual medical attendant of the patient. [Sec. 31.]

B. **Urgency Order.**—Must be signed by a near relative of the patient. If this is not done, the signatory must state why no near relative has signed, the circumstances under which he personally signed,

and his relationship to, or connection with, the patient. [Sec. 11 (3).]

Must state definitely that the signatory is of age, and has seen the patient within two days of the date of his signature. [Sec. 11 (4).]

Must have attached a medical certificate which may be signed either before or after the order, and a "statement of particulars." [Sec. 11 (1) and (7).]

Medical certificate accompanying must state clearly that the medical man himself examined the patient not more than two days before the date of reception [Sec. 29 (3)]; it must also state that it is necessary for the patient to be placed under control either for his own or the public safety, and the grounds on which such opinion is based. [Sec. 28 (3).]

Generally speaking, the medical certificate should comply with the same requirements as in reception order on petition, but it is not necessary that the medical man should examine separately from any other practitioner.

Urgency order remains valid for seven days from its date or until the petition is disposed of, if a petition for a reception order is pending, in which case such must be stated in the urgency order. [Sec. 11 (6).]

Admission of Private Patients.—When transferred from another hospital or private care.

1. Must be admitted if accompanied by a written order signed by a member of the Board of Control. [See 59 (1).]

2. If the patient has been detained under "Reception Order on Petition," there must accompany him:

(*a*) Order of removal signed by person authorised to discharge the patient.

(*b*) Written consent of a member of Board of Control. [Sec. 58.]

(*c*) Copies, certified to be true by manager of institution which patient has left, of re-

ception order, petition, statements, and certificates. [See 70 (3).]

3. If the patient has been admitted as a pauper and subsequently transferred to the private list, the order of removal must be signed by individual making last payment, or otherwise having authority to discharge, and must be accompanied by—

(*a*) Written consent of a member of the Board of Control. [Sec. 58.]

(*b*) Copies of original documents, certified correct as in 2 (*c*). [Sec. 70 (3).]

4. If detained under an urgency order, must be accompanied by:

Removal order as in 2 (*a*).

Consent of Commissioners.

Certified copies of urgency order and accompanying documents.

5. Sec. 19 (Act 1891).

If a patient who is detained in a hospital or licensed house becomes a pauper, the removal order may be signed by a J.P. The name of the hospital to which the removal has been ordered must be filled in, and copies of the original reception order and certificates accompany the removal order. The onus of informing the authority who previously was liable for the patient's maintenance of his intention to remove, rests upon the manager of the original hospital. The original reception order remains in force.

Service Patients

A new class has arisen since the war which is in many respects different from any others, viz. that of men serving in the Forces who have become insane, and whose disease is recognised as having been caused, or aggravated, by active service.

Such cases are maintained at the expense of the

Ministry of Pensions; are known as "Service Patients" and classified as "Private Patients." These cases are usually admitted from a military hospital under the provisions of the Army Act, Section 91, by an "order for the reception of a dangerous lunatic soldier"; the proceedings are similar in the case of the Royal Navy and R.A.F. This order for the reception is signed by an officer deputed by the Army Council so to do, who is usually the general commanding the district or area. One medical certificate is sufficient, embodying "facts observed by myself" and "other facts (if any)," with the customary statement of particulars, which is signed by the man's commanding officer. The medical certificate must be dated not more than seven clear days before the reception order, and the lunatic must be received within seven clear days from the date of such order. It will be noticed in this order and certificate that the patient is always referred to as "dangerous." Presumably, this must be read as "potentially dangerous to himself or others," otherwise this form would need frequently to be amended.

The position of any soldier or sailor thus admitted is safeguarded by the fact that the Board of Control have notified the medical superintendents of the counties that they should treat this man as a "Private Patient," and suggested that they should allow him to wear his own clothing when his friends are desirous and able to supply the same, "if they have reason to believe that he will ultimately be classified as such" (i.e. Service patient). This is a particularly wise proviso in view of the fact that it may be a matter of some time before the actual notification of the patient's classification as a "Service" case is received from the Ministry of Pensions.

In addition to the privileges of wearing clothing other than the ordinary hospital garb, these men may,

on their transfer to the "Service" class, be allowed, by *order* of the Committee, 2*s*. 6*d*. per week pocket money, if the medical superintendent certifies that they are capable of appreciating this allowance. As a service patient is on the legal footing of a private patient, a relative may order his release; as the State is responsible for his maintenance, apparently the nearest relative can do so, but if this is done in opposition to the medical superintendent's advice, the chance of the man being again received as a Service patient may be jeopardised, and, further, the Ministry have the power to stop part of the patient's pension. In the event of a "Service" patient who has been discharged *with* the approval of the medical superintendent being again received into the asylum, the medical superintendent, under certain circumstances, may immediately classify him as a service patient without waiting for the authority of the Ministry of Pensions.

Reception of Criminal Lunatics

The superintendent of any hospital must receive any criminal lunatic if the patient be accompanied by a warrant signed by a Secretary or Under Secretary of State subject to conditions as to infection as in case of pauper patients under summary reception order.

Schedule 2, Form 12 (*v.* Sec. 16).

ORDER FOR RECEPTION OF A PAUPER LUNATIC, OR LUNATIC WANDERING AT LARGE

I,.....having called to my assistance .....

of.....a duly qualified medical practitioner, and being satisfied that.....

of....., in the County of.....is a pauper in receipt of relief [in such circumstances as to require relief for h proper care and maintenance] and that the said.....is a .....and a proper person to be taken charge of and detained under care and treatment, that..... is a lunatic, and was wandering at large, and is a proper person to be taken charge of and detained under care and treatment.....

.....

.....

hereby direct you to receive the said..... as a patient into your Asylum. Subjoined is a Statement of particulars respecting the said.....

Signed,.....

A Justice of the Peace for the County of .....

Dated the.....day of.....192

To the Superintendent of the Asylum for the County of at

Schedule 2, Form 12 (*v.* Sec. 16).

STATEMENT OF PARTICULARS

STATEMENT OF PARTICULARS REFERRED TO IN THE ANNEXED ORDER

If any particulars are not known, the fact is to be so stated

[Where the patient is in the order described as an idiot, omit the particulars marked*]

The following is a Statement of Particulars relating to the said:

Name of Patient, with Christian name at length .....
.....

Sex and Age .. ..

*Married, Single or Widowed .. ..

*Rank, Profession, or previous Occupation (if any) .. ..

*Religious persuasion .. ..

Residence at, or immediately previous to the date hereof .. ..

*Whether first Attack .. ..

Age on first Attack .. ..

When and where previously under Care and Treatment as a Lunatic, Idiot, or person of unsound mind .. ..

*Duration of existing Attack .. ..

Supposed Cause .. ..

Whether subject to Epilepsy .. ..

Whether Suicidal .. ..

Whether Dangerous to others, and in what way .....

Whether any near Relative has been afflicted with Insanity .. ..

Union Parish to which Lunatic is chargeable.. .....

Name, Christian Names, and Full Postal Addresses of one or more Relatives of the Patient .. ..

Name of the Person to whom Notice of Death to be sent, and Full Postal Address, if not already given .. ..

Signed,.....
Relieving Officer of the.....

Dated the.....day of.....192

CERTIFICATE OF MEDICAL PRACTITIONER

In the matter of .....

of .....

in the County of.....

an alleged lunatic

I, the undersigned.....
do hereby certify as follows :—

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the Medical profession.

2. On the.....day of.....19

at .....

in the County of ....., separately from any other practitioner, I personally examined the said.....and came to the conclusion that he is a.....

and a proper person to be taken charge of and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating Insanity observed by myself at the time of examination, viz. :—

.....

.....

.....

(*b*) Facts communicated by others, viz. :—

.....

.....

.....

4. The said .....

appeared to me to be in a fit condition of bodily health to be removed to an Asylum.

5. I give this certificate having first read the Section of the Act of Parliament printed below.

Signed,.....

of .....

Dated this.....day of.....19 .

Extract from Section 317 of the Lunacy Act, 1890.

Any person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.

Schedule 2, Form 15 (*v.* Sec. 13).

ORDER FOR RECEPTION OF A LUNATIC NOT UNDER PROPER CARE AND CONTROL, OR CRUELLY TREATED OR NEGLECTED

To be made by a Justice appointed under the Lunacy Act, 1890

I, the undersigned,.....

being a Justice for the County of ..... specially appointed under the Lunacy Act, 1890, having caused.....

.....

to be examined by two duly qualified Medical Practitioners, and being satisfied that the said.....is a lunatic not under proper care and control [*or* is cruelly treated or neglected by the person having the care or charge of h] and that he is a proper person to be taken charge of and detained under care and treatment hereby direct you to receive the said.....

as a Patient into your Asylum.

Subjoined is a Statement of Particulars respecting the said.....

.....

Signed,..... .....

A Justice of the Peace for the County of .....,
appointed under the above-mentioned Act.

Dated the.....day of.....192 .

To the Superintendent of the Asylum.....

STATEMENT OF PARTICULARS

STATEMENT OF PARTICULARS REFERRED TO IN THE ANNEXED ORDER

If any particulars are not known, the fact is to be so stated

[Where the Patient is in the order described as an idiot, omit the particulars marked*]

The following is a Statement of Particulars relating to the said:

Name of Patient, with Christian name at length .. ..

Sex and Age .. ..

*Married, Single or Widowed .. ..

*Rank, Profession, or previous Occupation (if any) .. ..

*Religious persuasion .. ..

Residence at, or immediately previous to the date hereof .. ..

*Whether first Attack.. .. ..

Age on first Attack .. ..

When and where previously under Care and Treatment as a Lunatic, Idiot or person of unsound mind .. ..

*Duration of existing Attack .. ..

Supposed Cause.. .. ..

Whether subject to Epilepsy .. ..

Whether Suicidal .. ..

Whether Dangerous to others, and in what way .....

Whether any near Relative has been afflicted with Insanity.. .. ..

Union Parish to which the Lunatic is chargeable .. ..

Names, Christian Names, and Full Postal Addresses of one or more Relatives of the Patient .. ..

Name of the Person to whom Notice of Death to be sent, and Full Postal Address, if not already given.. .. ..

Signed,.....

Relieving Officer of the .....

Dated the.....day of .....192 .

Schedule 2, Form 8 (*v.* Secs. 4, 11, 16, 23 & 24).

CERTIFICATE OF MEDICAL PRACTITIONER

In the matter of .....

of .....

in the County of .....

an alleged lunatic.

I, the undersigned .....
do hereby certify as follows :

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the medical profession.

2. On the .....day of 192

at .....

in the County of ....., separately from any other practitioner, I personally examined the said .....

.....

and came to the conclusion that he is a .....

and a proper person to be taken charge of and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating Insanity observed by myself at the time of examination, viz. :—

.....

.....

.....

(*b*) Facts communicated by others, viz. :—.....

.....

.....

.....

4. The said .....
appeared to me to be in a fit condition of bodily health to be removed to an asylum.

5. I give this certificate having first read the section of the Act of Parliament printed below.

Signed, ...

of .....

Dated this .....day of .....One Thousand Nine Hundred and .....

Extract from Section 317 of the Lunacy Act, 1890.

Any person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.

CERTIFICATE OF MEDICAL PRACTITIONER

In the matter of .....

of .....

in the County of.....

an alleged lunatic.

I, the undersigned.....
do hereby certify as follows :

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the Medical profession.

2. On the.....day of.....192

at .....

in the County of ....., separately from any other practitioner, I personally examined the said.....

.....

and came to the conclusion that he is a.....

and a proper person to be taken charge of and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating Insanity observed by myself at the time of examination, viz. :—

.....

.....

.....

(*b*) Facts communicated by others, viz. :—.....

.....

.....

.....

4. The said.....
appeared to me to be in a fit condition of bodily health to be removed to an asylum

5. I give this certificate having first read the Section of the Act of Parliament printed below.

Signed,.....

of .....

Dated this.....day of.....One Thousand Nine Hundred and.....

Extract from Section 317 of the Lunacy Act, 1890.

ANY person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.

ORDER OF REMOVAL

To Wit. { *To the Superintendent of the.....Lunatic Asylum at .....*
and to the Superintendent of the.....Lunatic Asylum at .....

We, the undersigned, being two of the Sub-Committee of Visitors appointed for the charge and control of the..... Lunatic Asylum at..... ....., do hereby order and direct that....., a Pauper Lunatic chargeable to the.....in the County of ....., and now being in the said Lunatic Asylum at....., be removed to the said Lunatic Asylum at..... And we do hereby order and direct you, the said Superintendent of the said Lunatic Asylum at....., to remove the said Lunatic, and you the said Superintendent of the said Lunatic Asylum at ..... to receive the said Lunatic into the last-mentioned Asylum accordingly.

Given under our hands this.....day of .....One Thousand Hundred and .

ORDER OF REMOVAL.

To Wit. { *To the Relieving Officer of the .....*
.....in the County of....., To the
Superintendent of the County Lunatic Asylum at .....
.....in the County of.....
And to the Superintendent of the County Lunatic Asylum
at.....

We, the undersigned, being two of the Sub-Committee of Visitors appointed for the charge and control of the County Lunatic Asylum at....., do hereby order you, the Relieving Officer of the said..... to remove..... a Pauper Lunatic chargeable to the said.....and now being in the Lunatic Asylum at.....aforesaid to the.....County Lunatic Asylum at..... And we do also hereby order you the said Superintendent of the Lunatic Asylum at.....aforesaid to deliver the said Lunatic to the said Relieving Officer, and you, the said Superintendent of the.....County Lunatic Asylum at .....to receive the said Lunatic into the said last-mentioned Asylum accordingly.

Given under our hands this.....day of .....One Thousand Nine Hundred

Schedule 2, Form 1 (*v.* Secs. 4 & 5).

LUNACY ACTS, 1890 & 1891

In the matter of

a person alleged to be of unsound mind.

To

a Justice of the Peace for

or To His Honour the Judge of the County Court of

or To *Stipendiary Magistrate for*

The Petition of

of[1]

in the County of

1. I am[2] years of age.

2. I desire to obtain an order for the reception of

as a lunatic[3] in the

asylum [*or* hospital, *or* house] of

situate at[4]

3. I last saw the said

at

on the[5] day of

4. I am the[6] of the said

[or *if the petitioner is not connected with or related to the patient, state as follows :*—]

I am not related to or connected with the said

The reasons why this petition is not presented by a relation or connection are as follows :

---

1 Full postal address and rank, profession, or occupation.

2 At least twenty-one.

3 Or an idiot or person of unsound mind.

4 Insert a full description of the name and locality of the asylum, hospital, or licensed house, or the full name, address, and description of the person who is to take charge of the patient as a single patient.

5 Some day within 14 days before the date of the presentation of the petition.

6 Here state the connection or relationship with the patient.

The circumstances under which this petition is presented by me are as follows: [*state them*].

5. I am not related to or connected with either of the persons signing the certificates which accompany this petition as (*where the petitioner is a man*) husband, father, father-in-law, son, son-in-law, brother, brother-in-law, partner, or assistant, (*or where the petitioner is a woman*) wife, mother, mother-in-law, daughter, daughter-in-law, sister, sister-in-law, partner, or assistant.

6. I undertake to visit the said
personally, or by some one specially appointed by me at least once in every six months while under care and treatment under the order to be made on this petition.

7. A statement of particulars relating to the said
accompanies this petition.

If it is the fact add:

8. The said has been received in the asylum [*or* hospital, *or* house, *as the case may be*] under an urgency order dated the

The petitioner therefore prays that an order may be made in accordance with the foregoing statement.

Signed.....

Full Christian and Surname.

Date of presentation of the petition,.....

Schedule 2, Form 2 (Secs. 4, 5, 11).

STATEMENT OF PARTICULARS

STATEMENT OF PARTICULARS REFERRED TO IN THE ANNEXED PETITION.

The following is a Statement of Particulars relating to the said :

Name of Patient, with Christian name at length .. ..

Sex and Age .. ..

†Married, Single or Widowed .. ..

†Rank, Profession, or previous Occupation (if any) .. ..

† Religious persuasion .. ..

Residence at, or immediately previous to the date hereof .. ..

† Whether first attack .. ..

Age on first Attack .. ..

When and *Where* previously under Care and Treatment as a Lunatic, Idiot, or person of unsound mind .. ..

† Duration of existing Attack .. ..

Supposed Cause .. ..

Whether subject to Epilepsy .. ..

Whether Suicidal .. ..

Whether Dangerous to others, and in what way .....

Whether any near Relative has been afflicted with Insanity.. .. ..

Names, Christian Names, and Full Postal Addresses of one or more Relatives of the Patient .. ..

Name of the Person to whom Notice of Death to be sent, and Full Postal Address, if not already given.. .. ..

Name and full Postal Address of the usual Medical Attendant of the Patient .. ..

(Signed).....

When the petitioner or person signing an urgency order is NOT the person who signs the statement, add the following particulars concerning the person who signs the statement.

Name, with Christian name at length.

Rank, Profession, or Occupation (if any).

How related to or otherwise connected with the patient.

If any particulars are not known, the fact is to be so stated. [Where the patient is in the petition or order described as an idiot, omit the particulars marked †.]

ORDER FOR RECEPTION OF A PRIVATE PATIENT

To be made by a Justice appointed under the Lunacy Act, 1890. Judge of County Courts, or Stipendiary Magistrate.

I, the undersigned .....

(a) A Justice for —— specially appointed under the Lunacy Act, 1890; *or* the Judge of the County Court of ——, *or* the Stipendiary Magistrate for——

being (a) .....

.....

upon the petition of .....

(b) *Address and occupation.*

of (b) .....

in the matter of .....

(c) *Or* an idiot, *or* a person of unsound mind

a Lunatic (c) .....accompanied by the Medical Certificates of.....

and .....

(d) *Name of petitioner.*

hereto annexed, and upon the undertaking of the said (d) .....

.....to visit the said .....

personally or by some one specially appointed by the said (d) ....

.....once at least in every six months while under care and treatment under this Order, hereby authorise you to receive the said.....

(e) Asylum, *or* hospital, *or* house, *or* as a single patient.

as a Patient into your (e) .....

And I declare that I have [*or* have not] personally seen * the said.....

before making this Order.

Dated this.....day of.....19 .

(Signed) (a).....

A Justice for appointed under the above-mentioned Act [or *the Judge of the County Court of* or *a Stipendiary Magistrate*].

(f) *To be addressed to the medical superintendent of the asylum or hospital, or to the resident licensee of the house in which the patient is to be placed.*

To (f) .....

* *v.* Sec. 8.

Schedule 2, Form 8 (*v.* Secs. 4, 11, 16, 23 & 24).

CERTIFICATE OF MEDICAL PRACTITIONER

In the matter of.....

of .....

in the County of .....
an alleged lunatic.

I, the undersigned.....

do hereby certify as follows :

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the medical profession.

2. On the.....day of.....192

at .....

in the County of ....., separately from any other practitioner, I

personally examined the said.....

and came to the conclusion that he is a.....

and a proper person to be taken charge of and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating Insanity observed by myself at the time of examination, viz. :—

.....

.....

.....

(*b*) Facts communicated by others, viz. :—.....

.....

.....

.....

4. The said.....
appeared to me to be in a fit condition of bodily health to be removed to an Asylum.

5. I give this certificate having first read the Section of the Act of Parliament printed below.

Signed .....

of .....

Dated this.....day of.....One Thousand Nine Hundred and.....

Extract from Section 317 of the Lunacy Act, 1890.

Any person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.

Schedule 2, Form 4 (*v.* Sec. 11)

URGENCY ORDER

Form of URGENCY ORDER for the reception of a Private Patient into the .....

(Second Sched., 53 Vict., Form 4).

I, the undersigned, being a person twenty-one years of age, hereby authorise you to receive as a Patient into.....

.....

as a lunatic or person of unsound mind, whom I last saw at.....

.....

[1] Some day within two days before the date of the order.

on the [1].....day of.....192

I am not related to, or connected with, the person signing the Certificate, which accompanies this Order, in any of the ways mentioned in the margin.[2]

[2] Husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner, or assistant.

Annexed hereto is a Statement of Particulars relating to the said.....

Signed, ...

Rank, Profession, or Occupation (if any).....

Full Postal Address.....

How related to, or connected with, the Patient.....

.....

If not the husband or wife, or a relative, of the Patient, the person signing to state as briefly as possible—

1. Why the order is not signed by the husband or wife, or a relative of the Patient.....

.....

2. His or her connection with the Patient, and the circumstances under which he or she signs.....

.....

Dated this.....day of.....192

To the Medical Superintendent,

Schedule 2, Form 2 (Secs. 4, 5, 11).

STATEMENT OF PARTICULARS

Statement of Particulars referred to in the annexed Urgency Order.

The following is a statement of Particulars relating to the said :

N.B.—IF ANY PARTICULARS ARE NOT KNOWN, THE FACT TO BE SO STATED.

Name of Patient, with Christian name at length .. ..

Sex and Age .. ..

Married, Single, or Widowed .. ..

Rank, Profession, or previous Occupation (if any) .. ..

Religious persuasion .. ..

Residence at, or immediately previous to the date hereof .. ..

Whether first Attack .. ..

Age on first Attack .. ..

WHEN and WHERE previously under Care and Treatment as a Lunatic, Idiot, or person of unsound mind .. ..

Duration of existing Attack .. ..

Supposed Cause.. .. ..

Whether subject to Epilepsy .. ..

Whether Suicidal .. ..

Whether Dangerous to others, and in what way .....

Whether any near Relative has been afflicted with Insanity.. .. ..

Names, Christian Names, and Full Postal Addresses of one or more Relatives of the Patient .. ..

Name of the person to whom Notice of Death to be sent, and Full Postal Address, if not already given .. ..

Name and Full Postal Address of the usual Medical Attendant of the Patient .. ..

Signed .....

When the Petitioner or person signing an Urgency Order is not the Person who signs the Statement, add the following particulars concerning the person who signs the statement.

Name, with Christian Name at length .. ..

Rank, Profession, or Occupation .. ..

How related to or otherwise connected with the Patient .. ..

URGENCY CERTIFICATE

CERTIFICATE OF MEDICAL PRACTITIONER
(Schedule 2. Form 8.)

In the Matter of.....

of [1].....in the [2].....of.....

a [3].....an alleged Lunatic.

I, the undersigned..... do hereby certify as follows :—

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the Medical Profession.

2. On the.....day of.....190 , at [4]..... in the [5]..... of..... I personally examined the said..... and came to the conclusion that he is a lunatic or person of unsound mind, and a proper person to be taken charge of, and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating Insanity observed by myself at the time of Examination, [6] viz. :—

.....

.....

.....

(*b*) Facts communicated by others, [7] viz.—(State the NAME IN FULL of the person giving the information, with address and description)

.....

.....

.....

I, [8] certify that it is expedient for the welfare of the said .....

.....[or for the public safety] that the said..... should be forthwith placed under care and treatment.

My reasons for this conclusion are as follows:.....

.....

.....

4. The said..... appeared to me to be (*or* not to be) in a fit condition of bodily health to be removed to an Asylum.

5. I give this Certificate, having first read the Section of the Act of Parliament printed below.

Dated.....192 . Signed.....

Full Postal Address.....

.....

(1) Insert Residence of Patient.

(2) County, City or Borough, as the case may be.

(3) Insert Profession or Occupation (if any).

(4) Insert place of examination, giving the name of the street with No. or Name of the house, or should there be no number, the Christian and Surname of Occupier.

(5) County, City or Borough, as the case may be.

(6) If the same or other Facts were observed previous to the time of examination, the certifier is at liberty to subjoin them in a separate paragraph.

(7) The names and Christian names (if known) of informants to be given, with their Addresses and Descriptions.

(8) Statement accompanying Urgency Order.

EXTRACT FROM SECTION 317 OF THE LUNACY ACT, 1890.

"Any person who makes a wilful misstatement of any material fact in any Medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour."

APPLICABLE TO ENGLAND.

ORDER FOR THE RECEPTION OF A DANGEROUS LUNATIC SOLDIER.

WHEREAS, by the Army Act, section 91, as amended by the Army (Annual) Acts, 1899 and 1909, it is provided that the Army Council, or any Officer deputed by them for the purpose, may, if they or he think proper, on account of a soldier's lunacy, cause any soldier of the regular forces, on his discharge, to be sent to the parish or union to which under the statutes for the time being in force he appears, *from the statements made in his attestation paper, and other available information, to be chargeable*; and such soldier, *if delivered after reasonable notice*, in England or Ireland at the workhouse in which persons settled in such parish or union are received, and in Scotland to the inspector of poor of such parish, shall be received by the master or other proper officer of such workhouse, or such inspector of poor, as the case may be; and it is further provided by the said Act as so amended that the Army Council or any Officer deputed by them for the purpose, where it appears to them or him that any such soldier is a dangerous lunatic, and is in such a state of health as not to be liable to suffer bodily or mental injury by his removal, may, by order signified under their or his hand, send such lunatic direct to an asylum, registered hospital, licensed house, or other place in which pauper lunatics can legally be confined, and for the purpose of the said order the above-mentioned parish or union shall be deemed to be the parish or union from which such lunatic is sent, and that in England the lunatic shall be sent to the asylum, hospital, house or place to which a person in the workhouse aforesaid, on becoming a dangerous lunatic, can by law be removed; and it is further provided by the said Act, as amended by the Army (Annual) Acts, 1891, 1894, 1899, and 1909, that an order of the Army Council or Officer under section 91 of the Army Act, shall be of the same effect as a Summary Reception Order, within the meaning of the Lunacy Act, 1890; and the like proceedings shall be taken thereon as on an Order under that Act.[1]

1 NOTE.—Where the order directs the Lunatic to be received into any Asylum other than an Asylum of the County or Borough in which the Parish or Place from which the Lunatic is sent is situate, or into a Registered Hospital or Licensed House, it should state that the Army Council or Officer is satisfied that there is no Asylum of such County or Borough, or that there is a deficiency of room in such Asylum, or as the case may be, the special circumstances by reason whereof the Lunatic cannot conveniently be taken to an Asylum for such first-mentioned County or Borough.

And whereas it appears to me the undersigned being an Officer deputed by the Army Council for the purpose, from the statements made in the attestation paper of

a soldier, now of the Corps, but about to be discharged therefrom, and from other information, that the said is, or on his discharge will be, a pauper chargeable to the Parish of in the County [or Borough] of

And whereas it also appears to me from the Medical Certificate annexed that the said is a dangerous lunatic, and is in such a state of health as not to suffer bodily or mental injury by his removal.

And whereas it has been represented to me [that the Asylum at for the said County [or Borough] of] is a place to which a dangerous lunatic if an inmate of the Workhouse, of the said Union [or Parish] could by Law be removed.

Or "that there is a deficiency of room in the Asylum for the said County (or Borough) of [or some other special circumstances by reason whereof the Lunatic cannot conveniently be taken to the County or Borough Asylum], and that the Lunatic Hospital at or House near ."

Now I hereby order and desire you to receive the said , as a patient into your (*a*) . Subjoined is a statement of particulars respecting the said

(*a*) Insert—
1. Asylum,
2. Hospital, or
3. House.

(*b*) Dated the day of 192 .

(*b*) Signed.....

.....

(*b*) To be dated and signed by the Army Council or by any Officer deputed by them for the purpose.

To the Superintendent of the

Asylum for the County of ,

or, the Lunatic Hospital of *or*

Proprietor of the Licensed House of

[*Describe the Asylum, Hospital, or House.*

Statement of particulars relating to the said .....

IF ANY PARTICULARS IN THIS STATEMENT BE NOT KNOWN, THE FACT TO BE SO STATED.

Name of Patient, with Christian name at length .. ..) .....

Age .. ..

Married, Single, or Widower .. ..

Name or Number of Corps, and Rank .. ..

Religious persuasion .. ..

Whether first Attack .. ..

Age (if known) on first Attack .. ..

When and where previously under Care and Treatment .. ..) .....

Duration of existing Attack .. ..

Supposed Cause .. ..

Whether subject to Epilepsy .. ..

Whether Suicidal .. ..

Whether of temperate habits .. ..

Union or Parish to which the Lunatic appears to be chargeable .. ..) .....

Name and Address of Relative to whom Notice of Death to be sent .....) .....

Signed, *Name*, (*c*) .....

.....

.....

(*c*) To be signed by Officer Commanding Corps or Regiment.

MEDICAL CERTIFICATE.

I, he undersigned,

being a person registered under the Medical Acts, and being in the actual practice of the Medical Profession, hereby certify, that I, on the day of

(d) *Here insert the street and number of the house (if any) or other like particulars.*

at (d) in the County of personally examined

a Soldier of the Corps, and that the said Soldier is a dangerous Lunatic and a proper person to be taken charge of and detained under Care and Treatment, and is in such a state of health as not to suffer bodily or mental injury by his removal, and that I have formed this opinion upon the following grounds, viz. :—

(e) *Here state the facts.*

1. Facts indicating dangerous Insanity observed by myself (e)

(f) *Here state the information, and from whom received.*

2. Other facts (if any) indicating dangerous Insanity communicated to me by others (f) :

N.B.—Under the Lunacy Act, 1890, 53 Vic., cap. 5, Sec. 29 (1), the medical examination of the lunatic must take place not more than seven clear days before the date of the "reception order," and under Sec. 36 (3) of the Act, the Lunatic must be received before the expiration of 7 clear days from the date of the Order.

Signed, *Name* .....

Place of Abode .....

Dated this day of One Thousand Nine Hundred and

CHAPTER XIII

STATUTORY BOOKS, NOTICES, ETC.

STATUTORY BOOKS: Medical—Recertification, etc.—Escapes.
SPECIAL DUTIES at Inquests—Swearing of Affidavits.
DEATH OF PATIENT: Post-mortem Examination—Notices of death.

STATUTORY BOOKS—MEDICAL

The Rules of the Commissioners of the Board of Control make the keeping of the following medical books obligatory:

1. **Medical Register.**—Separate books (or parts of books) to be assigned for each sex and for private and pauper cases; (*a*) patients admitted direct from workhouse or on new orders; (*b*) patients admitted on transfer from another institution. 8 books or sections in all—4 for males and 4 for females. [Form 1B, Rules of B. of C. 1906.]

2. **Medical Journal.** [Form 3, Rules of B. of C. 1895.]

3. **Register of Mechanical Restraint.**—Medical particulars to be supplied by medical officer to Board of Control. [Form 5, Rules of B. of C. 1895.]

4. **Case Book.** [v. page 11.]

5. **Post-mortem Book.**—Separate books, etc. (or parts of books), may be kept for private patients. [Rule 1, 1906.]

In institutions receiving boarders, register of voluntary boarders, case book for voluntary boarders.

Notices of Admission to Board of Control.—In pauper or criminal cases along with this notice, which is prepared by the clerk, a medical statement by the

medical superintendent as to the mental and bodily condition of the patient is required. This statement must be made not earlier than two clear days or later than seven clear days after the admission—e.g. in the case of a patient admitted on the 10th day of a month, the statement must not be made earlier than the 13th or later than the 17th. [Rule 8, B. of C. 1895.]

In the case of private patients, the notice is sent by the clerk within one clear day of admission, but the statement by the medical superintendent at the same period as in the case of a pauper or criminal. At the expiration of a calendar month a report by the medical superintendent as to mental and bodily condition is required. [Rule 8, B. of C. 1895.]

Medical Journal.—Entries to be made once every week by the medical superintendent or an assistant medical officer, and every entry must be signed or initialed by the person making it. [Rule 10, B. of C. 1895; v. page 203.]

Case Book.—Within seven days after the admission of a patient the following particulars must be entered:

(*a*) Name, age, etc. (obtained from statement of particulars), and a copy of the facts contained in the medical certificate accompanying the reception order.

(*b*) Detailed description of the bodily condition of patient upon admission.

(*c*) Detailed description of the mental condition of patient upon admission.

Subsequent entries describing the progress of the case and recording the medical and other treatment must be made at least once a week for the first month after admission, afterwards in recent or curable cases at least once a month, and in chronic cases once in every three months. [v. page 11.]

All special circumstances, however, including seclusion and mechanical restraint, but especially

.....ASYLUM. FORM 1B OF SCHEDULE IN RU

Date of Admission, 1920.	Date of Discharge, Transfer, or Death.	NAME.		Civil State				Occupation (*as scheduled by the Commissioners in Lunacy*).			Previously Certified as Insane, stating number of times.	Age.			Attack.		
		Private. (Mark Criminal as such in red ink.)	Pauper.	Single.	Married.	Widowed.	Not known.	Schedule-symbols.				On Present Admission.	At Onset of Present Attack.	On First Attack (*if not a First Attack Case*).	Congenital.	First Attack.	Not First Attack.
								Group.	Sub-Group.	Sub-Division.							

Recoveries in an Institution or elsewhere.	Duration of the Present Attack from the Onset until Present Admission. *No entry to be made in respect to cases where the attack is congenital.*			Ætiological Factors (*as scheduled by the Commissioners in Lunacy*).		Bodily State on Admission.		Instances of Epilepsy.	Form of Mental Disorder (*as scheduled by the Commissioners in Lunacy*).	Deemed Suicidal by Medical Officer.	Observations (*for Congenital Physical Abnormalities, etc.*).
	Years.	Months.	Days.	Principal. Schedule-symbols. One Entry and one only to be made for each case in this column.	Contributory. Schedule-symbols. As many Contributory Factors as may be found are to be entered here.	General Health.	Names of Bodily Disease (if any).		Schedule-symbols. (One Symbol and one only to be entered in each case.)		

Signed..... .....

Rules of B. of C. 1895, Form 20.

PAUPER

SPECIAL REPORT AND CERTIFICATE

(Lunacy Act, 1890, Section 38; Lunacy Act, 1891, Section 7.)

No.....

[For use by Commissioners in Lunacy only.]

Name of Patient.....

Date of Admission.....*day of*.....1....

Date of reception order.....*day of*.....1....

I have this day seen and examined the above-named patient, and beg to report that, with regard to mental condition, he is

.....

.....

and, with regard to bodily condition, he is.....

.....

.....

and I hereby certify that he is still of unsound mind, and a proper person to be detained under care and treatment.

.....

Medical Superintendent

Dated the.....*day of*.....192

TO THE BOARD OF CONTROL.

all accidents and injuries must be at once fully and completely recorded. Every entry must be signed or initialed by the medical officer who made it.

Whenever required by the Board of Control the medical superintendent must supply them with a correct copy of any entries in the case or post-mortem books. [Rule 15, B. of C. 1895.]

Register of Mechanical Restraint.—Copy of all entries is to be sent by the medical superintendent to the Board of Control every quarter. If no restraint has been used during the quarter, a "NIL" return is to be sent. [Rule 18, B. of C. 1895.]

Renewals. [Sect. 38.]—These reports are of extreme importance, as they are the continuing instruments for the patient's detention, and should be carefully and accurately worded. Facts indicating insanity are required, but in recurrent and frequently relapsing cases, if the patient is in a clear and normal mental state at the time of recertification, this fact should be stated openly with a definite account of the exacerbations to which the case is liable. It may be necessary, particularly in deluded cases of long standing, to examine the patient on several occasions, and obtain reports from all the members of the staff with whom he comes in contact, before a reliable certificate can be written, as such cases are frequently well aware of the dates upon which their recertification is due, and are in consequence even more guarded in their statements and behaviour than usual. In cases of epilepsy, in addition to describing the mental symptoms, an account of the number, incidence, and variety of the fits should be given. Insane conduct, if recently observed in the particular patient, should always be included, as well as such obvious indications of continued insanity as hallucinations and false beliefs of all kinds. Finally, a note should be made of the

patient's general health, with a clear statement as to the existence of any physical ailment or injury.

Medical Journal.—The medical officers are personally responsible to the superintendent for the accuracy of the medical journal. This book, which is a statutory record, contains the names of all patients in the hospital who are undergoing medical treatment, and also of those who have sustained casualties, however slight. In many hospitals it is compiled from books kept in the wards and signed by the medical officer as being correct. The journal is made up weekly, and must be signed by the officer who is responsible for the treatment of the patients whose names are included.

Medical Register. [Form 1 B.]—This record, which is the source of a large number of statistics, is kept by the senior medical officer on either side of the house. It contains the patient's name in full, age and civil state, age on this and previous attacks, whether first attack or not, and spaces for ætiological factors and diagnosis. In addition, there are spaces for the symbols which the Board of Control have laid down to represent the various factors and diseases for purposes of tabulation. From the above brief description and the accompanying specimen page it will be clearly recognised that it is not possible to complete this register accurately until (1) the case is well known and (2) a full history has been obtained. It is, therefore, usual for this book to be kept posted up to within three months of date, and not later. The clinical record, or case sheet, in most institutions has headings printed which correspond with the columns in the medical register, and these spaces are best left blank until the medical register is being completed for that individual patient; considerably greater accuracy and a much fuller knowledge of the history is then assured.

Even when a full history has been obtained, it is frequently impossible to assign any definite factor as the exciting cause in some cases, and this is clearly recognised, and a symbol laid down for such cases. The best way to deal with this register is for two medical officers to work together, one reading out the facts and completing the clinical case sheet, and the other entering the particulars in the register ; this latter should at first be done in pencil, and, when completed, in ink.

Escapes. (Sec. 85, Lunacy Act, 1890, and Criminal Lunatics Act, 1884, Sec. 11.)—From time to time it occurs in all large hospitals that a patient succeeds in eluding the vigilance of the staff and making his escape. He may simply escape from a country walking party, or whilst at work on the farm, or, on the other hand, as the result of weeks of labour during which he has succeeded in loosening all the screws in a window ; the ways in which patients have escaped from institutions are so many and various that it is impossible to enumerate them all, and a really " determined " escape is a most difficult man to handle. As in suicidal cases, the real safeguard against escape lies in the supervision exercised by the staff—if that is defective, escapes will always occur. With the more general adoption of the parole system, they are likely to increase even with the utmost care in selection of patients, as with the desire to give every man who is improving as much liberty as possible, a certain number of cases who either deliberately or impulsively break their parole is inevitable. An escape in itself does not sound a particularly dreadful or alarming incident, but the point is not so much the actual absence of the patient from the hospital, as the possibility of such accidents as suicide or violence.

Once any patient has made an attempt at escaping,

NOTICE OF ESCAPE

I hereby give you Notice, That .....

.....a Pauper Patient received into this

Asylum on the.....day of.....1 ,

escaped therefrom on the.....day of

.....191 .

The state of mind of the patient at the time of h escape

was as follows:..... ....

.....

The circumstances and manner of the escape were as follows :

....

....

.....

Clerk of the Asylum.

Dated the.....day of.....One

Thousand Nine Hundred and.....

To the Board of Control.

whether successful or not, it is almost always found that he will make others, and an entry in the case book will warn succeeding medical officers of this particular propensity, and also against employing the patient in such situations as may afford him further opportunities.

The steps usually taken when a patient is known to have escaped from the estate are to send two reliable men—if possible, who are well acquainted with the patient's appearance—to any address at which it is considered likely that he may seek sanctuary. It is customary also to notify the police, both locally and in the parish within which the patient's friends reside, as well as the relieving officer of the parish to which the patient is chargeable. Patients should never be regarded as having escaped until a complete and exhaustive search has been made of all corridors, cupboards, etc., in which concealment could possibly be effected. Unless such possibilities are excluded, much time and trouble may be expended in searching outside for a patient who has never left the building. An escaped patient may be recaptured at any time within fourteen days of his escape, failing which he must be written off the books, and cannot again be received into an asylum without fresh orders and certificates. An exception to the preceding rule exists, however, in the case of criminal lunatics ; it is laid down by the Act that they " may be retaken at any time " ; what the exact legal position would be of a patient who escaped previous to the expiration of his sentence and avoided recapture until the sentence had run out, it is difficult to say.

The clerk of the hospital has certain statutory duties to perform in the case of an escape, which it is as well that the medical officer should know. A notice which includes, besides the patient's name and mental state, a full description of the circumstances

NOTICE OF RECAPTURE

I hereby give you Notice, That .....

.....a Pauper Patient who was received into this Hospital on the..... day of .....19.., and escaped therefrom on the.....day of.....19..., was on the.....day of.....19..., recaptured under the following circumstances:

.....

.....

.....

.....

.....

Clerk of the Hospital.

Dated the.....day of.....19

To the Board of Control.

CAUTION TICKET ISSUED IN THE CASE OF DETERMINED ESCAPES

.....

Issued.....192 .

Ward .....

(*Sd.*).....

Date of Removals	Wards	
	To	From

under which the escape or recapture took place, must be sent to the Board of Control " within two clear days after " both escape and recapture (Commissioners' Rules, 23, 1). An escaped patient may be retaken by any member of the staff of the hospital from which he got away, by the police or by the relieving officer of the parish in which he is discovered, or by anybody else " authorised in writing " by the superintendent.

Inquests.—In mental hospitals, when a patient dies suddenly, or following an injury which might possibly have accelerated death, the coroner is likely to hold an inquest, and in this case the A.M.O. will be called upon to give evidence—(1) as to the injury or accident, (2) as to the post-mortem findings. His evidence, therefore, in the first place, will be

purely as to fact, and should be as concise and free from medical terms as possible—he should express no opinions until definitely asked for them by the coroner or jury. If the relatives are openly hostile and making accusations as to the treatment of the patient or the general administration of the hospital, the coroner may be relied upon to investigate all complaints of this kind, and the A.M.O. should wait for him to ask questions with reference to the relatives' dissatisfaction before giving any explanation. As a matter of fact, in the modern hospital, it is exceptional to have to deal with unreasonable relatives or jurymen, but the possibility is always present and must be kept in mind. When the case is one in which there has been a fracture or operation previous to death, the p.-m. examination cannot be considered complete unless the fracture is cut down upon and exposed, or the operation wound fully opened up so as to show the result; the coroner will almost certainly desire to inspect the lesion before holding the inquest. Similarly, if the case be one of impaction of food in the trachea, the viscus should be opened up, but the obstruction allowed to remain *in situ* until the coroner has seen it.

Deaths.—Following the death of a patient, after the remains have been washed and shrouded by the nurse, the body is removed on a bier to the mortuary, with a label affixed giving particulars of the patient. The mortuary, to which a fitted post-mortem room is usually attached, is commonly a building entirely separate from the hospital, but in a central position as nearly as possible equidistant from male and female sides, and adjacent to the main gate. This obviates any necessity for funerals to be witnessed by the patients, and adds to the convenience of relatives who may be present.

Before any body is fastened down in the coffin, it is essential for the patient to be identified by a member of the staff from the ward in which he or she died.

Post-mortem Examination.—In practically all the modern mental hospitals it is usual to hold an autopsy on as large a number of deceased patients as possible, but before any p.-m. is ordered it is absolutely necessary to make certain that the relatives have not notified an objection to the performance of any such proceeding. The copy of rules sent to the relatives immediately the patient is admitted, usually contains a note that in the event of death taking place, an examination will be performed unless the relatives have notified their objection in writing previously. The post-mortems are performed, either by one A.M.O. who has received special pathological training, or by the doctor who had charge of the patient previous to death.

In any case the actual work of removing the organs is usually performed by a trained attendant; the examination of each individual organ then being made by the medical officer.

In the event of any point of special importance being known to exist, it is advisable for the doctor to give instructions that the part or organs affected shall not be removed except under his supervision.

It cannot be too strongly insisted upon that the examination should in all cases be as complete as possible. A fixed order of investigation of the organs should be rigidly adhered to: the gut must be opened in its whole length, and then spread out with the mucous surface upwards, on a separate table if possible; the weighing of the organs must be carefully and accurately performed, and the post-mortem book filled up as soon as the actual examination of the remains is complete.

These notes should be as full and as carefully kept

NOTICE OF DEATH

Name.....Reg. No.....
Admitted.....Age at Death.....
Occupation.....Religion.....
DIED.....192 , at..... . m.

CAUSE OF DEATH.	Duration of Disease from onset.			
	Years.	Calendar Months.	Days.	Hours.
Primary † (1)				
Secondary ‡ (2) .... (Contributory)				
.....				
.....				

Whether or not ascertained by Post-mortem Examination .. ..

Time, and any unusual circumstances attending the death; also a description of any injuries known to exist at time of death or found subsequently on the body of deceased or a statement that there were none .. ..

Names and description of persons present at death .. ..

Whether or not mechanical restraint was applied to deceased within seven days previously to death, with its character and duration if so applied.. .. ..

Age at onset of Last Attack of Mental Disorder .. .. | Age at First Attack (if not a first attack case)....

DURATION OF LAST ATTACK OF MENTAL DISORDER—

From its onset until last admission.....years,.....months, ...days.

Since admission .....years,.....months, ...days.

FORMS OF MENTAL DISORDER (as scheduled by the Board of Control).

On admission (Schedule-Symbol) .....At Death..... (Schedule-Symbol.....

† *i.e.*, the disease which initiated the train of events leading to death, and not a mere secondary contributory, or immediate cause, or a terminal condition or mode of death.

‡ A terminal condition or mode of death should not be entered as a secondary (or contributory) cause.

.....
Medical Superintendent.

TO THE CLERK OF THE ASYLUM.

as the case book records, as it is frequently necessary to refer to them, and at times long after the patient's death.

All bruises, abrasions, or signs of injury of any kind, however trivial, and whether known to exist previous to death or not, must be noted, and it is usual to describe them on the official "cause of death" sent to the medical superintendent. In the event of the discovery of any serious injury, such as broken ribs or some ruptured viscus, *not known* to be present, the A.M.O. should inform his superintendent immediately, as the latter may desire to see the injuries for himself before the examination is proceeded with, and the parts possibly further disturbed.

As already indicated, recent fractures or surgical operations should be exposed and examined; this is absolutely necessary in view of the possibility of the coroner deciding to hold an inquest.

When the examination is completed, and the post-mortem register filled up, it is customary for the A.M.O. to write out for the superintendent a statement of the cause of death which should, as above mentioned, also contain a list of injuries or marks of disease should any such be present.

An extract of the p.-m. notes should also be entered in the clinical record before the latter is filed.

Affidavits.—In the absence of his superintendent, a medical officer may be called upon to swear an affidavit in the case of a patient. In most mental hospitals it is customary for the medical superintendent to visit a commissioner for oaths (whose fee is 2*s*. and 1*s*. 4*d*. for each exhibit).

If, on the other hand, the commissioner visits the mental hospital, the fee is usually somewhat higher. These fees are payable by the relatives of the patient concerned, and should be obtained before the affidavit is sworn.

INDEX

Acts, Army, 170
  Criminal Lunacy, 170
  Lunacy, 169
  Mental Deficiency, 170
Administrative buildings, 7
Adolescent insanity, 47
Affidavits, 212
Alcohol, 88
Amylene hydrate, 34
Anæsthetics, 69
Appendicitis, 69
Artificial feeding, 54
Automatism in epilepsy, 101

Bath, continuous, 4, 47, 88
  electric, 49
  Turkish, 48, 89
  wet pack, 49
Bathing of new cases, 129
Bed sores, 11, 115
Bladder, rupture of, 69, 125
Board of Control, 168
Book, case, 11, 199, 200
  post-mortem, 199
Books, statutory, 199
Bromides, 33
Bromidia, 33

Case book, 11, 199, 200
    entries, rules for, 11
  sheet, 130, 131
  taking, 129
Casualties, 16
  form of report in, 70, 71, 72
Certificates, medical, 191
Chilblains, 166
  in epileptics and general paralytics, 73
Chloral hydrate, 32, 33
Choking, prevention of, 73
  treatment of, 73
Circulatory disorders, 166
Classification of patients, 2
Clothing, persistent removal of, 116
Complaints, patients', 13, 81
Confinements, 62
Contagious diseases in new cases, 127
Contagious diseases, 151
Correspondence of patients, 133
Criminal Lunatics Act, 170
Criminal lunatics, reception of, 177
Croton oil, 36

Death, notice of, 211
Deaths, 209
Dementia, primary, 49, 83, 116
Dementia, senile, 73, 74, 147
Depression, states of, 84
  treatment of, 85 *et seq.*
Destruction of clothing, 79
Destructiveness, 117
Diarrhœa, 110
Diet, 17
  for epileptics, 100
  ordering of, 12
  ordinary, 27
  summary, 14, 15
Discharge, question of, 143
  of criminal lunatics, 150
  in epilepsy, imbecility, and melancholia, 146
  in paranoia and senile dementia, 147
  of pauper patients, 148
  of private patients, 148
Dysentery, 155
  caution ticket in, 157
  treatment of, 158

Emergencies, 20
Enquiry Form, 132, 133
Enteric fever, 160
    carriers, 162
    recommendations of Board of Control, 162
Entertainments, 64, 65, 66, 67
Epilepsy,
  automatism in, 101
  choking in, 73
  diet in, 100
  employment in, 51
  falls in, 105
  furor in, 52
  lumbar puncture in, 64
  masked, 101
  periodicity in, 101
  status epilepticus, 6, 33, 100
  treatment, 98
Epileptic chart, 100, 101

Escapes, 204
caution ticket, 208
notice of, 205
Excitement, states of, 78
treatment of, 80

Feeding, artificial, 54, 55, 56, 57
in excitement, 80
Filth eating, 119
Fire duties, 76

Gangrene, 167
Gastric ulcer, ruptured, 69
General paralysis:
bed sores, 111
choking, 73
congestive seizures, 111
diet, 109
employment, 51, 109
liability to diarrhœa, 110
injury, 110
lumbar puncture, 64
question of discharge, 112
treatment by anti-specific methods, 111
tube-feeding, 112
unexplained pyrexia, 110
Guardians, notice to, on admission, 124

Habits, treatment of faulty, 114, 115
Hæmatoma auris, 165
Hanging, 91
Hernia, strangulated, 69
Herpes zoster, 166
Homicidal patients, 96
Hospitals, County Mental, 169
registered, 169
Houses, licensed, 169
Hydrotherapy, 46
Hyoscine, 35
Hyoscyamine, 35
Hypnotics, use of, 30

Imbeciles, 105
masturbation in, 106
physical drill for, 107
Incontinence of urine, 75
Inquests, 208
Insane, legal control of, 168
Insomnia, 81
causes of, 83
treatment of, 84 *et seq.*

Journal, Medical, 200, 203

Keys, 7
Knives, home-made, 59

Laryngotomy, 69
Leave of absence for patients, 67 (Sect. 55)
Letters of inquiry from relatives, 136
Lord Chancellor, 168
Lumbar puncture, 63
Lunacy Acts, 169
masters in, 168

Mania, 35, 36, 78; *see also* States of Excitement
Massage, 89
Masturbation, 106, 115
Medical examination room, 4
Medical officer:
fire duties, 76
interest in sport, 19
leave of absence, 20
notebook, private, 19
relationship to medical superintendent, 17
relationship to subordinate staff, 18
rounds of, 10
Medicines, administration and ordering of, 37, 40
Medinal, 34
Melancholia, 34, 36, 49, 89
amenorrhœa in, 61
thyroid in, 89
Menstruation, 60
Mental deficiency (*see* Imbeciles), 105
Mental Deficiency Act, 170
Mental Hospitals, 2
Mercier, late Dr. Chas. A., 1

New cases, admission of, 122 *et seq.*
Night observation, 6
Notes, statutory, 12, 13
Notice of death, 211
of escapes, 205
of illness, accident, etc., 127, 140, 141
of recaptures, 207
to Charge Nurse on admission of new cases, 128
to Guardians, on admission of new cases, 124
to relatives, 136
Notices of admission to Board of Control, 199

Operating theatre, 5
Operations, surgical, 68
Opium, 34, 35
Orders for reception of criminal lunatic, 177
for reception of dangerous lunatic soldier, 195
for reception of lunatic not under proper care and control, 178–81

Orders for reception of private patient, 190
for reception of pauper lunatic or lunatic wandering at large, 178
of removal to Relieving Officer, 186
of removal to Superintendent, 185
urgency, 192, 193, 194

Paraldehyde, 32
Paranoia, 146
Parotitis, 164
Patients, accurate knowledge of, 18
Patients' clothing, 17
Patients, employment of, 49 *et seq.*
leave of absence for, 67 (Sect. 55)
register of, 199
searching of, 59
Patients, Service, and their reception, 175
Patients (single care), 169
Pauper patients, reception of, 170
Pessaries, 61
Petition in case of private patients, 187, 188
judicial order on, 172
urgency order on, 173
Poisoning, 94
Post-mortem book, 199
examination, 210
Precipitation, 94
Pregnancy, 62
Private patients, admission of, on transfer, 174
reception of, 172
Psycho-analysis, 41
Pulmonary tuberculosis, 152
Pyorrhœa alveolaris, 55
Pyrexia, unexplained, in general paralytics, 110

Ravenous feeding, 120
Recapture, notice of, 207
Reception of patients, 168
orders (*see* Orders), 170 *et seq.*
Recoveries, 143
Refusal of admission of pauper patients, 171
Refusal of food, 54
Register, mechanical restraint, 199, 202
medical, 200
of patients, 199
Renewals, special report and certificate, 201 (Form 213)
Restraint, mechanical, 54
Ribs, fracture of, 125
Rubbish, hoarding of, 119

Scabies, 163
Searching of patients, 59
Seclusion, 52
Sedatives, 30
Self-mutilation, 118
Service patients, 175
Shingles, 166
Sleep chart, 82
Soldier, order for the reception of a dangerous lunatic, 195 *et seq.*
Spitting, 113
Staff, new, education of, 22
examination of, 21
medical treatment of, 23
Statement of particulars, 189
Status epileptics, 6, 33, 100
Strangulation, 91
Struggles with patients, 70
records and report, 71
Suicidal parchments, 16, 90, 92
patients, 89, 95
exercising of, 95
Sulphonal, 30, 31, 32

Teeth, artificial, 61
extraction of, 99
Tetronal, 34
Thyroid, 36, 89
Tracheotomy, 69
Transfer, admission of private patient on, 174
reception of pauper patient on, 171
Treatment, dietetic, 27
general, 25
medicinal, 30
open-air, 25, 26
Trials extended, in alcoholic and drug cases, 145
Trional, 34
Tuberculosis, 152, 153

Urgency order, 173, 192, 193, 194
Urine, incontinence of, 75
retention of, 74

Veronal, 33, 34
Visiting of patients, 88, 137
Visitors' rules, 137
passes, 138

Wards, acute admission, 3
arrangement of, 3
chronic, 6
convalescent, 6
infirmary, general, and special, 4
observation, 5
working patients, 6
Weighing, 57, 58, 59
Weight chart, 58
Widal reaction, 161

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